

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH														
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND														
CERTIFICATE OF DEATH														
11950														
1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b> c. LENGTH OF STAY IN 1b <b>2451 days</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Deer's Head State Hospital</b>					2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Dorchester</b> ✓ c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Cambridge</b> d. STREET ADDRESS <b>RFD 1</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
3. NAME OF DECEASED (Type or print) First <b>William</b> Middle <b>Abbott</b> Last <b>Abbott</b>					4. DATE OF DEATH Month <b>October</b> Day <b>3</b> Year <b>19 61</b>									
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Oct. 1884</b>		9. AGE (In years last birthday) <b>77</b> yrs.						
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Waterman</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Fishing</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Deal Island, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		IF UNDER 1 YEAR Months <b>7</b> Days <b>7</b>						
13. FATHER'S NAME <b>Unknown</b>					14. MOTHER'S MAIDEN NAME <b>Unknown</b>									
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>					16. SOCIAL SECURITY NO. <b>None</b>					17. INFORMANT <b>Campbell Robbins</b> Address <b>Robbins, Maryland</b>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral thrombosis</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>Generalized arteriosclerosis</b> DUE TO (b) <b>Generalized arteriosclerosis</b> (c) <b>Generalized arteriosclerosis</b> INTERVAL BETWEEN ONSET AND DEATH <b>2 weeks</b> <b>10 years</b>														
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Diabetes mellitus</b>										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>					20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>					20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				
20f. (City or town)					20g. (County)					20h. (State)				
21. I certify that (I) (this hospital) attended the deceased from <b>Jan. 17, 1955</b> to <b>Oct. 3, 1961</b> , that (I) (we) last saw the deceased alive on <b>Oct. 2, 1961</b> , and that death occurred at <b>7:30 A.M.</b> from the causes and on the date stated above.														
22a. SIGNATURE <b>Lee L. Lawry</b> M.D.					ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>					22b. DATE SIGNED <b>10/3/61</b>				
22c. PHYSICIAN'S NAME (Type) <b>Lee L. Lawry, M. D.</b>					22d. ADDRESS <b>Deer's Head State Hospital; Salisbury, Md.</b>									
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>					23b. DATE THEREOF <b>Oct. 6, 1961</b>					23c. NAME OF CEMETERY OR CREMATORY <b>Sandy Island Cemetery</b>				
23d. LOCATION (City, town or county) <b>Andrews, Md.</b>					23e. (State)									
24. FUNERAL DIRECTOR'S SIGNATURE <b>LeCompte Funeral Service Cambridge, Md.</b>					ADDRESS					25a. REC'D BY REGISTRAR <b>DATE OCT 6 '61</b>				
										25b. REGISTRAR'S SIGNATURE <b>William S. House</b>				

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Laconia Funeral Service Center, Inc.

Oct. 3, 1961, Laconia, New Hampshire

and family

1961

Jan. 11, 1961, Laconia, N.H.

Oct. 2, 1961

Laconia, N.H.

x

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

12005

## CERTIFICATE OF DEATH

11991

<b>1. PLACE OF DEATH</b> a. COUNTY <b>Wicomico</b> <b>MARYLAND</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b> c. LENGTH OF STAY IN 1b <b>17 days</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Deer's Head State Hospital</b>			<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Talbot</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Easton</b> d. STREET ADDRESS <b>202 Port Street</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
<b>3. NAME OF DECEASED</b> (Type or print) <b>Emma Gibson Allen</b>			<b>4. DATE OF DEATH</b> <b>October 7 1961</b>					
<b>5. SEX</b> <b>Female</b>			<b>6. COLOR OR RACE</b> <b>Colored</b>					
<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			<b>8. DATE OF BIRTH</b> <b>Dec. 25, 1898</b>					
<b>9. AGE</b> (In years last birthday) <b>62 yrs.</b>			<b>10. IF UNDER 1 YEAR</b> Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b>					
<b>11. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Laborer</b>			<b>12. KIND OF BUSINESS OR INDUSTRY</b> <b>Domestic</b>					
<b>13. FATHER'S NAME</b> <b>Henry Gibson</b>			<b>14. MOTHER'S MAIDEN NAME</b> <b>EMMA Adams</b>					
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <b>No</b>			<b>16. SOCIAL SECURITY NO.</b> <b>073-20-1448</b>					
<b>17. INFORMANT</b> <b>Robert H. Gibson - Easton, Md.</b>			<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <b>331X</b> IMMEDIATE CAUSE (a) <b>Recurrent cerebral hemorrhage</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>331X</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>331X</b>			<b>INTERVAL BETWEEN ONSET AND DEATH</b> <b>3 min.</b>		
<b>20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (If either, notify medical examiner) <input type="checkbox"/>			<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)					
<b>20c. TIME OF INJURY</b> Month, Day, Year <b>19</b> Hour a.m. <b>5:05 P.M.</b> p.m.			<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>					
<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)			<b>20f. (City or town)</b> <b>Easton</b> (County) <b>MARYLAND</b> (State)					
<b>21. I certify that (I) (this hospital) attended the deceased from</b> <b>Sept. 20, 1961</b> <b>to</b> <b>October 7, 1961</b> , that (I) (we) last saw the deceased alive on <b>October 7, 1961</b> , and that death occurred at <b>5:05 P.M.</b> M, from the causes and on the date stated above.								
<b>22a. SIGNATURE</b> <b>V. Juerman</b>			<b>22b. DATE SIGNED</b> <b>10/9/61</b>					
<b>22c. PHYSICIAN'S NAME</b> (Type) <b>V. Juerman, M.D.</b>			<b>22d. ADDRESS</b> <b>Deer's Head State Hospital; Salisbury, Md.</b>					
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <b>Burial</b>			<b>23b. DATE THEREOF</b> <b>Oct. 10, 1961</b>					
<b>23c. NAME OF CEMETERY OR CREMATORY</b> <b>Richards Cem.</b>			<b>23d. LOCATION</b> (City, town or county) <b>Easton</b> (State) <b>MARYLAND</b>					
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <b>James B. Kiel</b>			<b>25a. REC'D BY REGISTRAR</b> <b>OCT 11 '61</b>					
<b>25b. REGISTRAR'S SIGNATURE</b> <b>Arthur L. Kline</b>								



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VR A15 (4)  
15M 9/60

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

12006

11992

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Wicomico</u> <b>MARYLAND</b>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>SOMERSET</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>DEAL ISLAND</u>							
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SALISBURY</u>				c. LENGTH OF STAY IN 1b <u>3 WEEKS</u>							
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>082 PENINSULA General Hospital</u>				d. STREET ADDRESS <u>MAIN ROAD 19X-2</u>							
<b>3. NAME OF DECEASED</b> (Type or print) <u>BARBARA JANE Anderson</u>				<b>4. DATE OF DEATH</b> <u>October 26, 1961</u>							
<b>5. SEX</b> <u>FEMALE</u>		<b>6. COLOR OR RACE</b> <u>White</u>		<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> <b>WIDOWED</b> <input type="checkbox"/> DIVORCED <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <u>AUG-13-1943</u>					
<b>9. AGE</b> (In years last birthday) <u>18</u> yrs. <table border="1"> <tr> <td>IF UNDER 1 YEAR</td> <td>IF UNDER 24 HRS.</td> </tr> <tr> <td>Months</td> <td>Days</td> </tr> </table>		IF UNDER 1 YEAR	IF UNDER 24 HRS.	Months	Days	<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Machine operator</u>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>GARMENT INDUSTRY</u>		<b>11. BIRTHPLACE</b> (County & State, or foreign country) <u>MARYLAND</u>	
IF UNDER 1 YEAR	IF UNDER 24 HRS.										
Months	Days										
<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.A</u>				<b>13. FATHER'S NAME</b> <u>LEVIN ANDERSON</u>							
<b>14. MOTHER'S MAIDEN NAME</b> <u>FLORIS WILLING</u>				<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <u>NO</u>							
<b>16. SOCIAL SECURITY NO.</b> <u>UNKNOWN</u>				<b>17. INFORMANT</b> <u>LEVIN ANDERSON - DEAL ISLAND MD</u>							
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).]											
<b>PART I. DEATH WAS CAUSED BY:</b>											
IMMEDIATE CAUSE (a) <u>Metastatic Sarcoma</u>											
DUE TO (b) <u>Osteogenic Sarcoma left thigh</u>											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c)											
<b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)</b>											
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
<b>20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</b>											
<b>20b. DESCRIBE HOW INJURY OCCURED.</b> (Enter nature of injury in Part I or Part II of item 18.)											
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. p.m. <u>19</u>		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town) (County) (State)</b>					
<b>21. I certify that (I) (this hospital) attended the deceased from <u>50 October, 1961</u> to <u>26 Oct</u>, 1961, that (I) <del>was</del> last saw the deceased alive on <u>October 26, 1961</u>, and that death occurred at <u>5:30 PM</u>, from the causes and on the date stated above.</b>											
<b>22a. SIGNATURE</b> <u>Joseph C. Fitzgerald</u>				<b>22b. DATE SIGNED</b> <u>28 Oct 61</u>							
<b>22c. PHYSICIAN'S NAME (Type)</b>				<b>22d. ADDRESS</b>							
<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>Burial</u>		<b>23b. DATE THEREOF</b> <u>10-29-61</u>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>ST. JOHN'S METHODIST</u>		<b>23d. LOCATION (City, town or county) (State)</b> <u>DEAL ISLAND MD</u>					
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <u>D. S. Webster</u>				<b>25a. REC'D BY REGISTRAR</b> <u>DA NOV 3 '61</u>							
<b>25b. REGISTRAR'S SIGNATURE</b> <u>Arthur S. Thomas</u>											

MEDICAL CERTIFICATION



20652



MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

12007

Item 8 Film 6798 10/26/61 iwk

11993

1. PLACE OF DEATH a. COUNTY <b>XXX Wicomico</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Wicomico</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>				c. LENGTH OF STAY IN 1b <b>12</b> d. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Pen Gen Hospital</b>				e. STREET ADDRESS <b>1226 N. Division St</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>MAUDE ETHEL ARBOGAST</b>				4. DATE OF DEATH Month Day Year <b>OCTOBER 20th 1961</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>1893</b> <b>Dec. 13, 1893</b>	9. AGE (In years, lost birthday) <b>67</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House Work at Home</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>		11. BIRTHPLACE (State or foreign country) <b>Dunmore-W. Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>	
13. FATHER'S NAME <b>William K. Jackson</b>				14. MOTHER'S MAIDEN NAME <b>G. Anna Siple</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO.		17. INFORMANT <b>Mr John D. Arbogast (Son) #66 Phillips Ave. Norwood, Mass.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Con gestive HEART FAI LUKE</b> <b>585X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause lost. (b) <b>Ventricular Tachycardia</b> DUE TO (c) <b>Acute Cholecystitis</b>						INTERVAL BETWEEN ONSET AND DEATH <b>2 days</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>N/A</b>					
20c. TIME OF INJURY Month, Day, Year Hour o. m. <b>N/A</b> 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>N/A</b>		20f. (City or town) (County) (State) <b>N/A</b>	
21. I certify that (I) (this hospital) attended the deceased from <b>9:20 P.M.</b> 19 <b>1961</b> , that (I) (we) last saw the deceased alive on <b>19</b> , and that death occurred at <b>M.</b> from the causes and on the date stated above.							
22a. SIGNATURE <b>Dr. Gray Reeves</b>				22b. DATE <b>Oct. 23/ 1961</b>		22c. PHYSICIAN'S NAME (Type) <b>Dr. John M. Bloxon</b>	
22d. ADDRESS <b>Medical Center - Salisbury, Maryland</b>				22e. SIGNATURE <b>Arthur S. House</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Oct. 23, 1961</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Parsons Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Salisbury, Maryland</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>HOLLOWAY &amp; COMPANY</b>				ADDRESS <b>SALISBURY, MARYLAND</b>		25a. REC'D BY REGISTRAR DATE <b>OCT 24 '61</b>	
				25b. REGISTRAR'S SIGNATURE			





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

12008

11994

<b>PLACE OF DEATH</b> a. COUNTY <b>WICOMICO</b> <b>MARYLAND</b>		<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution: Residence before admission) e. STATE <b>Maryland</b> b. COUNTY <b>Worcester</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Pocomoke</b>	
c. LENGTH OF STAY IN lb <b>58 days</b>		d. STREET ADDRESS <b>112 Oak St.</b>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Deer's Head State Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>James E. Ardis</b>		4. DATE OF DEATH <b>October 27, 1961</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <b>March 6, 1894</b>
9. AGE (In years last birthday) <b>67 yrs.</b>		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Carpenter</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Building</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Worcester Co., Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Charlie Ardis</b>		14. MOTHER'S MAIDEN NAME <b>Haddie Landing</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No --</b>		16. SOCIAL SECURITY NO. <b>220-12-1910</b>	
17. INFORMANT <b>Mrs Helen G. Ardis, Pocomoke City, Md.</b>		Address <b>112 Oak St.</b>	
18. CAUSE OF DEATH (Enter only one cause possible for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Thrombosis</b> 332 X DUE TO Conditions, if any, which gave rise to immediate cause (b) <b>Generalized Arteriosclerosis</b> (c) <b>10 yrs.</b> DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Rheumatoid Arthritis</b>		INTERVAL BETWEEN ONSET AND DEATH <b>2 yrs.</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>Aug. 30, 1961</b> to <b>Oct. 27, 1961</b> , that (I) (we) last saw the deceased alive on <b>Oct. 27, 1961</b> , and that death occurred <b>10:50 A.M.</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>Lee L. Lawry</b>		22b. DATE SIGNED <b>10/27/61</b>	
22c. PHYSICIAN'S NAME (Type) <b>Lee L. Lawry, M.D.</b>		22d. ADDRESS <b>Deer's Head State Hospital Salisbury, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>10-29-61</b>	
23c. NAME OF CEMETERY <b>First Baptist</b>		23d. LOCATION (City, town or county) (State) <b>Pocomoke City, Maryland</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Henry H. Watson</b>		25. REC'D BY REGISTRAR <b>OCT 31 '61</b>	
ADDRESS <b>Pocomoke City, Md.</b>		25b. REGISTRAR'S SIGNATURE <b>Charles L. Hanna</b>	



*[Faint, illegible handwritten text]*

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

1  
12009  
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH  
11995

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SALISBURY</u>				c. LENGTH OF STAY IN 1b <u>7 Days</u> <u>Nanticoke</u>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>PENINSULA General Hospital</u>				d. STREET ADDRESS			
3. NAME OF DECEASED (Type or print) <u>VIVIAN W. BARCLAY</u>				4. DATE OF DEATH Month <u>October</u> Day <u>29</u> Year <u>1961</u>			
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>NEGRO</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. AGE (In years last birthday) <u>55</u> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Domestic</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Cook</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Wm. E. Wallace</u>				14. MOTHER'S MAIDEN NAME <u>Rose Smith</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>155-10-1734</u>			
17. INFORMANT <u>Rose Wallace</u>				Address <u>Nanticoke, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Thrombosis of coronary Artery</u> <u>584X</u> DUE TO (b) <u>Cholelithiasis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				INTERVAL BETWEEN ONSET AND DEATH <u>8 days</u> <u>Indefinite</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour <u>19</u> e.m. p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>22 Oct</u> , 19 <u>61</u> , to <u>29 Oct</u> , 19 <u>61</u> , that (I) (we) last saw the deceased alive on <u>29 Oct</u> , 19 <u>61</u> , and that death occurred at <u>8:41</u> M, from the causes and on the date stated above.							
22a. SIGNATURE <u>E. A. Purcell</u>				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <u>E. A. Purcell</u>				22d. ADDRESS <u>652 W Main St, Salisbury, Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF <u>11/5/61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Nanticoke Com. Nanticoke, Md.</u>		23d. LOCATION (City, town or county) (State)	
24. FUNERAL DIRECTOR'S SIGNATURE <u>W. J. Jessen, Biville, Md.</u>				25a. REC'D BY REGISTRAR <u>DA NOV 2 '61</u>		25b. REGISTRAR'S SIGNATURE <u>Charles S. Hume</u>	

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# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

12010

11996

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> <span style="float: right;">MARYLAND</span>				2. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Somerset</u>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Westover</u>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Peninsula General Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Mollie</u> Middle <u>M.</u> Last <u>Beacham</u>				4. DATE OF DEATH Month <u>October</u> Day <u>24</u> Year <u>1961</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov. 9, 1889</u>	9. AGE (In years and birthday) <u>71</u> yrs.	IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u>	IF UNDER 24 HRS. Hours <u>  </u> Min. <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Domestic</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Cook</u>	11. BIRTHPLACE (County & State, or foreign country) <u>Va.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Pleaz Bryant</u>				14. MOTHER'S MAIDEN NAME <u>Jennie Poore</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>  </u>				16. SOCIAL SECURITY NO. <u>097-20-2638</u>			
17. INFORMANT <u>Jess Beacham R.I.B. 25D Westover, Md.</u>				Address <u>  </u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Aspiration of Gastric Contents</u> <u>153.8</u> DUE TO (b) <u>Acute Gastric Dilation</u> Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. (c) <u>Postoperative Radical Excision of Ca. of Colon</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <u>  </u>						INTERVAL BETWEEN ONSET AND DEATH <u>2+ hours</u> <u>6 days</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour <u>  </u> e.m. <u>  </u> p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)		(County)	(State)	
21. I certify that (I) (this hospital) attended the deceased from <u>10/19, 1961</u> to <u>10/24, 1961</u> ; that (I) (we) last saw the deceased alive on <u>10/24, 1961</u> , and that death occurred at <u>1:30 PM</u> , from the causes and on the date stated above.							
22a. SIGNATURE <u>Donald R. McWilliams</u> M.D.				ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <u>Peninsula General Hospital</u>				22d. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>10-29-61</u>	23c. NAME OF CEMETERY OR CREMATORY <u>St. Mary's Cem.</u>	23d. LOCATION (City, town or county) <u>Princess Anne</u>		(State) <u>Md.</u>		
24. FUNERAL DIRECTOR'S SIGNATURE <u>Samuel S. ...</u>				25a. REGISTRAR'S SIGNATURE <u>  </u>		25b. REGISTRAR'S SIGNATURE <u>  </u>	

TO HO...  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 12 hours after death.

01031

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Blauvelt, John



VS. A15ME  
5M 7/59

Item 8 Film G297 10/17/61 iwb

11997

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)		f. COUNTY	
c. LENGTH OF STAY IN lb		d. STREET ADDRESS	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)		4. DATE OF DEATH	
5. SEX		6. AGE (In years last birthday)	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH	
9. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10. BIRTHPLACE (State or foreign country)	
11. FATHER'S NAME		12. CITIZEN OF WHAT COUNTRY?	
13. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		14. SOCIAL SECURITY NO.	
15. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hemorrhage due to gunshot wounds of chest and abdomen 976X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		16. INTERVIEWED YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
17. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		18. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.)	
19. TIME OF INJURY Month, Day, Year Hour a.m. 1:40 P.M. 10-8-61		20. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Own home. Salisbury Wicomico Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		22. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
23. ACTUAL SIGNATURE EXAMINER'S NAME (Type)		24. DATE SIGNED	
25. EXAMINER'S NAME (Type)		26. DATE SIGNED	
27. BURIAL, CREMATION, REMOVAL (Specify)		28. DATE THEREOF	
29. NAME OF CEMETERY OR CREMATORY		30. LOCATION (City, town, or country) (State)	
31. FUNERAL DIRECTOR		32. ADDRESS	
33. REC'D BY REGISTRAR		34. REGISTRAR'S SIGNATURE	



# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

12012

11998

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Peninsula General Hospital</u>				e. STREET ADDRESS <u>Alabama Avenue</u>			
3. NAME OF DECEASED (Type or print) <u>George</u> First <u>Henry Bloodsworth</u> Middle <u>Henry</u> Last <u>Bloodsworth</u>				4. DATE OF DEATH <u>October 18</u> 19 <u>61</u> Month <u>10</u> Day <u>18</u> Year <u>1961</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Aug 9 1879</u> 82 yrs.	
9. AGE (In years last birthday) <u>82</u>		IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u>		IF UNDER 24 HRS. Hours <u>0</u> Min. <u>0</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Salesman</u>				11. BIRTHPLACE (County & State, or foreign country) <u>Somerset Co., Md.</u>			
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>							
13. FATHER'S NAME <u>George A. Bloodsworth</u>				14. MOTHER'S MAIDEN NAME <u>Mary Jones</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>Denwood Bloodsworth; Mt Vernon Md.</u>			
17. INFORMANT <u>Denwood Bloodsworth; Mt Vernon Md.</u>				18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> 331X DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>1 day</u> (c) <u>INTERVAL BETWEEN ONSET AND DEATH</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>October 15, 1961</u> to <u>October 18, 1961</u> , that (I) (we) last saw the deceased alive on <u>October 18, 1961</u> , and that death occurred at <u>4:05 PM</u> , from the causes and on the date stated above.							
22a. SIGNATURE <u>William R. Ellis</u> M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>10-23-61</u>	
22c. PHYSICIAN'S NAME (Type)				22d. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>10/21/61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Parsons</u>		23d. LOCATION (City, town or county) (State) <u>Salisbury Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>James Linman</u>				25a. REC'D BY REGISTRAR <u>Nov 1 '61</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Krum</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, fill in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

\$1091



# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

12013

11999

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Wicomico</u> <span style="float: right;">MARYLAND</span>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Parsonsborg</u>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Peninsula General Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>3. NAME OF DECEASED</b> (Type or print) <u>ALICE MARIE Bull</u>				<b>4. DATE OF DEATH</b> Month <u>October</u> Day <u>12</u> Year <u>1961</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> <u>Single</u>		8. DATE OF BIRTH <u>Oct. 12, 1961</u>	
9. AGE (In years last birthday) <u>0</u> yrs.		IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u>		IF UNDER 24 HRS. Hours <u>5</u> Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Salisbury, Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U S A</u>							
13. FATHER'S NAME <u>Robert Henry Bull</u>				14. MOTHER'S MAIDEN NAME <u>Doris Ann Riley</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>None</u>			
17. INFORMANT <u>Father- R.D.# 1 Parsonsborg, Md.</u>							
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).]							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Aspiration Pneumonitis</u> (b) <u>Perinatal Hypoxia</u> (c) <u>Two loops of cord around neck</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>10/12, 1961</u> to <u>10/12, 1961</u> , that (I) (we) last saw the deceased alive on <u>10/12, 1961</u> , and that death occurred at <u>10:27 AM</u> , from the causes and on the date stated above.							
22a. SIGNATURE <u>Alfred C. Kells</u>				22b. DATE SIGNED <u>10/24/61</u>			
22c. PHYSICIAN'S NAME (Type) <u>DR. A.C. Kells</u>				22d. ADDRESS <u>Medical Center, Salisbury, Maryland</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Oct. 13, 1961</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Parsonsborg Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Salisbury, Maryland</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>HOLLOWAY &amp; COMPANY</u>				25a. REC'D BY REGISTRAR <u>OCT 17 '61</u>			
25b. REGISTRAR'S SIGNATURE <u>Wm. S. Thoms</u>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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W.C. Ellis

UNION, Oct. 13, 1901

London Cemetery

HOLWAY & COMPANY EMBROIDERY MANUFACTURERS



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH																	
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND																	
CERTIFICATE OF DEATH																	
1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>SALISBURY</u> c. LENGTH OF STAY IN 1b <u>MARYLAND</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>PENINSULA GENERAL HOSPITAL</u>						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE <u>Maryland</u> b. COUNTY <u>Worcester</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Pocomoke</u> d. STREET ADDRESS <u>238-2</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
3. NAME OF DECEASED (Type or print) <u>Baby Boy</u>			4. DATE OF DEATH <u>October 13</u> 19 <u>61</u>			5. SEX <u>Male</u>			6. COLOR OR RACE <u>Colored</u>								
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>			8. DATE OF BIRTH <u>October 13, 1961</u>			9. AGE (In years last birthday) <u>2</u> yrs.			IF UNDER 1 YEAR Months Days Hours Min. <u>45</u>								
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Infant</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Maryland</u>			11. BIRTHPLACE (County & State, or foreign country) <u>U.S.A.</u>			12. CITIZEN OF WHAT COUNTRY?								
13. FATHER'S NAME <u>William Collier</u>						14. MOTHER'S MAIDEN NAME <u>Ester Cottman</u>											
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)						16. SOCIAL SECURITY NO.						17. INFORMANT <u>William Collier - Pocomoke, Md.</u> Address					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>abruptio placentae</u> 761.0 DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause last. DUE TO (c)												INTERVAL BETWEEN ONSET AND DEATH					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)												19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)												20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)					
21. I certify that (I) (this hospital) attended the deceased from <u>12</u> to <u>6 A.M.</u> , 19 <u>61</u> , that (I) (we) last saw the deceased alive on <u>19</u> , and that death occurred at <u>6 A.M.</u> from the causes and on the date stated above.																	
22a. SIGNATURE <u>James P. Gallahue M.D.</u>						ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>						22b. DATE SIGNED					
22c. PHYSICIAN'S NAME (Type)						22d. ADDRESS											
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				23b. DATE THEREOF <u>10-14-61</u>				23c. NAME OF CEMETERY OR CREMATORY <u>Tinsley Chapel</u>				23d. LOCATION (City, town or county) (State) <u>Pocomoke, Md.</u>					
24. FUNERAL DIRECTOR'S SIGNATURE <u>Edgar Wharton - New Church, Va.</u>						25a. REC'D BY REGISTRAR <u>OCT 20 '61</u>						25b. REGISTRAR'S SIGNATURE <u>Arthur S. Thomas</u>					

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Wicomico</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>911 S.Division St</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>CALEB</b> Middle <b>CALVIN</b> Last <b>COOPER</b>		4. DATE OF DEATH Month <b>OCTOBER</b> Day <b>21</b> Year <b>19 61</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>March 9, 1874</b>
9. AGE (In years lost birthday) <b>87</b> yrs.		10. IF UNDER 1 YEAR: Months <b>87</b> Days <b>87</b> Hours <b>87</b> Min. <b>87</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Construction Foreman</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Surry Virginia</b>	
11. BIRTHPLACE (State or foreign country) <b>U S A</b>		12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>	
13. FATHER'S NAME <b>Joshua Cooper</b>		14. MOTHER'S MAIDEN NAME <b>Sarah Thompson</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Unk</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>Unk</b>	
17. INFORMANT <b>Mrs Mary A. Cooper (Wife)</b> Address <b>911 S.Division St Salisbury, Maryland</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Generalized Carcinomatosis</b> 154X DUE TO <b>Carcinoma of Rectum</b> Conditions, if any, which gave rise to immediate cause (c), stating the <u>under</u> lying cause lost. (b) <b>2 yrs</b> (c) <b>2 yrs</b>		INTERVAL BETWEEN ONSET AND DEATH <b>3 mon</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>N/A</b>	
20c. TIME OF INJURY Month, Day, Year Hour o. m. <b>N/A</b> p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>N/A</b>	20f. (City or town) <b>N/A</b> (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>July 19 61</b> to <b>10 21 61</b> , that (I) (we) last saw the deceased alive on <b>10 21 19 61</b> and that death occurred at <b>9:15 P.M.</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>[Signature]</b>		22b. DATE SIGNED <b>Oct. 23/ 1961</b>	
22c. PHYSICIAN'S NAME (Type) <b>Dr. Henry A. Briele</b>		22d. ADDRESS <b>Medical Center - ,Salisbury, Maryland</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>Oct. 23, 1961</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Wicomico Memorial Park</b>	23d. LOCATION (City, town, or county) (State) <b>Salisbury, Maryland</b>
24. FUNERAL DIRECTOR'S SIGNATURE <b>HOLLOWAY &amp; COMPANY</b> ADDRESS <b>SALISBURY, MARYLAND</b>		25a. REC'D BY REGISTRAR <b>DATE OCT 24 '61</b> 25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>	

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DEPARTMENT OF HEALTH

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

12016

12002

1. PLACE OF DEATH a. COUNTY <b>Wicomico</b>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE <b>Maryland</b> b. COUNTY <b>Wicomico</b>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>SALISBURY</b>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>PENINSULA General HOSPITAL</b>		d. STREET ADDRESS <b>R.F.D.#2</b>	
3. NAME OF DECEASED (Type or print) First <b>John</b> Middle <b>LAMAR</b> Last <b>DOWERS</b>		4. DATE OF DEATH Month <b>October</b> Day <b>10</b> Year <b>1961</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>NEGRO</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>March 3, 1961</b>
9. AGE (In years last birthday) <b>7</b> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	
11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>John Dowers</b>		14. MOTHER'S MAIDEN NAME <b>Elizabeth Johnson</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>John Dowers, R.F.D. 2 Salis - Md.</b>	
17. INFORMANT <b>John Dowers, R.F.D. 2 Salis - Md.</b>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>acute gastro-enteritis</b> DUE TO (b) <b>Pneumonia</b> DUE TO (c) <b>493X</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>10/8/61</b> , 19 <b>61</b> , to <b>10/10/61</b> , 19 <b>61</b> , that (I) (we) last saw the deceased alive on <b>10/10/61</b> , 19 <b>61</b> , and that death occurred at <b>10:23 AM</b> , from the causes and on the date stated above.			
22a. SIGNATURE <b>Carrie Deam</b> M.D.		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <b>CHARLIE HEARN</b>		22d. ADDRESS <b>226 N. W. Main St.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>		23b. DATE THEREOF <b>10/14/1961</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Mt. Calvary</b>		23d. LOCATION (City, town or county) (State) <b>Fruitland Md.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Clinton H. Stewart Salis - Md.</b>		25a. REC'D BY REGISTRAR <b>Oct 19 '61</b>	
ADDRESS		25b. REGISTRAR'S SIGNATURE <b>Clinton S. Hearn</b>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

12017

## CERTIFICATE OF DEATH

12003

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Wicomico</u> <u>MARYLAND</u>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>				c. LENGTH OF STAY IN 1b <u>7 days</u>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Deer's Head State Hospital</u>				d. STREET ADDRESS <u>Phillip Morris Drive</u>			
<b>3. NAME OF DECEASED</b> (Type or print) First <u>Edythe</u> Middle <u>Cornelia</u> Last <u>Dunlap</u>				<b>4. DATE OF DEATH</b> Month <u>October</u> Day <u>12</u> , Year <u>1961</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>12/19/93</u>	
9. AGE (In years last birthday) <u>67</u> yrs.		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u>		IF UNDER 24 HRS. Hours <u>  </u> Min. <u>  </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>  </u>		11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME <u>Willis H. Fisher</u>				14. MOTHER'S MAIDEN NAME <u>Isabella Dawson</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give year or dates of service) <u>  </u>				16. SOCIAL SECURITY NO. <u>090-22-4612</u>		17. INFORMANT <u>Deer's Head State Hospital Records, Salisbury</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchial pneumonia - bilateral</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Chronic partial intestinal obstruction</u> DUE TO (c) <u>Peritoneal adhesions</u>				INTERVAL BETWEEN ONSET AND DEATH <u>5 days</u> <u>2 yrs</u> <u>10 yrs</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Parkinson's disease</u>				19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>  </u>					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>  </u> p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>  </u>		20f. (City or town) (County) (State) <u>  </u>	
21. I certify that (I) (this hospital) attended the deceased from <u>Oct. 5th., 1961</u> , to <u>Oct. 12th., 1961</u> that (I) (we) last saw the deceased alive on <u>October 12, 1961</u> , and that death occurred at <u>1:35 AM</u> from the causes and on the date stated above.							
22a. SIGNATURE <u>Lee L. Lawry</u>				22b. DATE SIGNED <u>10/12/61</u>		22c. PHYSICIAN'S NAME (Type) <u>Lee L. Lawry, M. D.</u>	
22d. ADDRESS <u>Deer's Head State Hospital, Salisbury, Md.</u>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>OCT. 16, 1961</u>		23c. NAME OF CEMETERY OR CREMATORY <u>NORTH WOOD CEMETERY PH. LADELPHIA</u>		23d. LOCATION (City, town or county) (State) <u>PENNA</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Thomas J. Wallace</u>				25a. REC'D BY REGISTRAR <u>  </u>		25b. REGISTRAR'S SIGNATURE <u>Arthur L. Thomas</u>	
25c. ADDRESS <u>Salisbury, Md.</u>				DATE <u>OCT 16 '61</u>			

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James William Johnston  
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# 12018 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12004

1. PLACE OF DEATH a. COUNTY <b>Wicomico</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE <b>Maryland</b>		b. COUNTY <b>Somerset</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>		c. LENGTH OF STAY IN lb		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Westover</b>		d. STREET ADDRESS <b>19 X 2</b>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Peninsula General Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		4. DATE OF DEATH Month Day Year <b>10-5-61</b> <b>19</b>			
3. NAME OF DECEASED (Type or print) <b>Flora</b>		First Middle Last <b>Dunn</b>		5. SEX <b>F</b>		6. COLOR OR RACE <b>W</b>	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>June 14, 1909</b>		9. AGE (In years last birthday) <b>52</b>		IF UNDER 1 YEAR Months Days <b>52</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>North Carolina</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Turner Foster</b>		14. MOTHER'S MAIDEN NAME <b>Laura Waston</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <b>Mr Russell Dunn Westover, Md.</b>	
17. INFORMANT <b>Mr Russell Dunn Westover, Md.</b>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Ruptured Aneurysm thoracic aorta</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>0 22 X</b>		INTERVAL BETWEEN ONSET AND DEATH <b>1 Hr. 40 Min</b>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
ACTUAL SIGNATURE <b>Earl L. Royer</b> EXAMINER'S NAME (Type) <b>Earl L. Royer, M.D.</b> <b>407 Camden Ave. Salisbury, Md.</b>		DATE SIGNED <b>10-9-61</b>		22a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>		22b. DATE THEREOF <b>10-8-61</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>St. Andrew Cemetery</b>		22d. LOCATION (City, town, or country) (State) <b>Princess Anne, Md.</b>		23. FUNERAL DIRECTOR <b>Princess Anne, Md.</b>		24a. REC'D BY REGISTRAR <b>OCT 13 '61</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur S. Thomas</b>							

VS. A15ME  
5M 7/59

**TO DEPUTY MEDICAL EXAMINER:** This certificate should be executed within 24 hours after death. If a delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

**TO FUNERAL DIRECTOR:** Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1943



Wisconsin

Salisbury

Salisbury General Hospital

Flora

June 14, 1943

North Carolina

Laurel Station

Mr. Russell Brown Watson, Esq.

Salisbury General Hospital

10-1-41

Salisbury, Md.

St. Anne's Hospital, Prince Anne, Md.

Prince Anne, Md.

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

12019

12005

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Peninsula General Hospital</u>				2. USUAL RESIDENCE (Where deceased lived, if institutions: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Worcester</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Ocean City MD</u> d. STREET ADDRESS <u>Rt 2nd St</u> e. IS RESIDENCE ON A FARM? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Mary Taylor Gaskins</u>				4. DATE OF DEATH Month Day Year <u>October 27 1961</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>May 29, 1896</u>	
9. AGE (In years last birthday) <u>65 yrs.</u>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>OWN HOME</u>		11. BIRTHPLACE (County & State, or foreign country) <u>BERLIN MD</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>L. HAZZARD TAYLOR</u>		14. MOTHER'S MAIDEN NAME <u>ANGIE BAKER</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>	
16. SOCIAL SECURITY NO. <u>219-03-0090</u>		17. INFORMANT <u>Mr. FRANK GASKINS, OCEAN CITY MD</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Ventricular Fibrillation</u> 433.1 } DUE TO Conditions, if any, which gave rise to immediate cause (b) } (a), stating the underlying cause last. } DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>immediate</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <u>Kidney Infection, Gastric ulcer</u>				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour e.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>10.17</u> , 19 <u>61</u> , to <u>10.27</u> , 19 <u>61</u> , that (I) (we) last saw the deceased alive on <u>10.27</u> , 19 <u>61</u> , and that death occurred at <u>11 P.M.</u> , from the causes and on the date stated above.							
22a. SIGNATURE <u>H. H. Briele</u>				22b. DATE <u>10.28.61</u>		22c. PHYSICIAN'S NAME (Type) <u>H. H. Briele</u>	
22d. ADDRESS <u>Medical Center Salisbury MD</u>				22e. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>10/30/61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>EVERGREEN CEM</u>		23d. LOCATION (City, town or county) (State) <u>BERLIN MD</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Anna A. Burbox</u>				25a. REC'D BY REGISTRAR <u>Berlin MD</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

(M)

12012

12012

Washington  
D.C.  
May 19, 1946

Taylor

May 19, 1946

Dear Mr. Taylor  
Enclosed for you are  
two copies of a report

(I)

dated May 18, 1946, from  
the Federal Bureau of  
Investigation, Washington, D.C.

Very truly yours,  
J. Edgar Hoover

1946

W. H. R. Circle  
W. H. R. Circle

Enclosed for you are  
two copies of a report  
dated May 18, 1946, from  
the Federal Bureau of  
Investigation, Washington, D.C.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
12020					12006				
1. PLACE OF DEATH					2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)				
a. COUNTY <u>Wicomico</u> <u>MARYLAND</u>					a. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u>				
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Delmar</u>					c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Delmar</u>				
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>200 Railroad Avenue</u>					d. STREET ADDRESS <u>200 Railroad Avenue</u>				
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
3. NAME OF DECEASED (Type or print)					4. DATE OF DEATH				
First Middle Last					Month Day Year				
<u>RACHEL ELIZABETH GERMAN</u>					<u>Oct. 21 19 61</u>				
5. SEX <u>Female</u>					6. COLOR OR RACE <u>White</u>				
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>					8. DATE OF BIRTH <u>9-12-1875</u>				
9. AGE (In years last birthday) <u>86</u> yrs.					IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>At Home</u>					10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>				
11. BIRTHPLACE (County & State, or foreign country) <u>Laurel, Del.</u>					12. CITIZEN OF WHAT COUNTRY? <u>USA</u>				
13. FATHER'S NAME <u>Benjamin Hill</u>					14. MOTHER'S MAIDEN NAME <u>Unknown</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>					16. SOCIAL SECURITY NO. <u>None</u>				
17. INFORMANT <u>Carrie Ada Prevette, Delmar, Md.</u>					Address				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]									
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral thrombosis</u>									
Conditions, if any, which gave rise to immediate cause (b) <u>Arteriosclerosis</u>									
(c) <u>332 X</u> DUE TO									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Prior cerebral thromboses</u>									
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)									
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>									
20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> et work <input type="checkbox"/> et work <input type="checkbox"/>									
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)									
20f. (City or town) (County) (State)									
21. I certify that (I) (this hospital) attended the deceased from <u>2/1</u> , 19 <u>55</u> , to <u>death</u> , 19 <u>61</u> , that (I) (we) last saw the deceased alive on <u>Oct 20</u> , 19 <u>61</u> , and that death occurred at <u>12:45</u> PM, from the causes and on the date stated above.									
22a. SIGNATURE <u>Ernest M. Lammore</u> M.D.									
22b. DATE SIGNED <u>10/21/61</u>									
22c. PHYSICIAN'S NAME (Type) <u>E. M. LAMMORE</u>									
22d. ADDRESS <u>DELMAR, DEL.</u>									
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>									
23b. DATE THEREOF <u>10-24-61</u>									
23c. NAME OF CEMETERY <u>Trinity</u>									
23d. LOCATION (City, town or county) (State) <u>Laurel, Del. RT.</u>									
24. FUNERAL DIRECTOR'S SIGNATURE <u>W. S. Marvel Co - Delmar, Del.</u> ADDRESS									
25a. REC'D BY REGISTRAR <u>OCT 24 '61</u>									
25b. REGISTRAR'S SIGNATURE <u>Arthur S. Hines</u>									

05681

*[Faint handwritten signature]*

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove corban papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
ISM 9/59

1  
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

12021

12007

1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Wicomico</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Pen Gen Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>CHARLES</b> Middle <b>EDWARD</b> Last <b>GIBBONS</b>		4. DATE OF DEATH Month <b>OCTOBER</b> Day <b>30th</b> Year <b>19 61</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Jan. 14, 1881</b>
9. AGE (In years last birthday) <b>80</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS. Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Robert P. Gibbons Retired Farmer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Pittsville, Maryland</b>	
11. BIRTHPLACE (State or foreign country) <b>U S A</b>		12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>	
13. FATHER'S NAME <b>Robert Gibbons</b>		14. MOTHER'S MAIDEN NAME <b>Gertrude Rounds</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>N/A</b>	
17. INFORMANT <b>Mrs. Mazie P. Gibbons (Wife)</b>		18. ADDRESS <b>R.D.# 2 Salisbury, Maryland</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.0 Anteriosclerotic Heart Disease</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Due to</b> (c) <b>Due to</b>		INTERVAL BETWEEN ONSET AND DEATH <b>1 yr</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Pneumonia, Acute</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <b>N/A</b>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>N/A</b>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>N/A</b> p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>N/A</b>		20f. (City or town) <b>N/A</b> (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>1:30 P.M.</b> to <b>19</b> , that (I) (we) last saw the deceased alive on <b>19</b> , and that death occurred on <b>19</b> , from the causes and on the date stated above.			
22a. SIGNATURE <b>David J. Gilmore</b>		22b. DATE SIGNED <b>Oct. 30, 1961</b>	
22c. PHYSICIAN'S NAME (Type) <b>Dr. David J. Gilmore</b>		22d. ADDRESS <b>Medical Center Salisbury, Maryland</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Nov. 1, 1961</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Parsons Cemetery</b>		23d. LOCATION (City, town, or county) <b>Salisbury, Maryland</b> (State)	
24. FUNERAL DIRECTOR'S SIGNATURE <b>HOLLOWAY &amp; COMPANY</b>		25a. REC'D BY REGISTRAR <b>OCT 31 '61</b>	
ADDRESS <b>SALISBURY MARYLAND</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur L. Hays</b>	

12021

CONTRACT OF DEATH

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

12022

## CERTIFICATE OF DEATH

12008

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> <u>MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Worcester</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Ocean City R.F.D.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Peninsula General Hospital</u>		d. STREET ADDRESS <u>Indian Knoll 23X-1</u>	
3. NAME OF DECEASED (Type or print) First <u>Richard</u> Middle <u>Fuller</u> Last <u>Hall</u>		4. DATE OF DEATH Month <u>October</u> Day <u>7</u> Year <u>1961</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov. 10, 1902</u>
9. AGE (In years last birthday) <u>58</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Real Estate Developer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Business</u>	11. BIRTHPLACE (County & State, or foreign country) <u>Brooklyn New York</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Richard F. Hall Sr.</u>	
14. MOTHER'S MAIDEN NAME <u>Mary C. Benson</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give year or dates of service)	
16. SOCIAL SECURITY NO. <u>No</u>		17. INFORMANT <u>Mrs. R. F. Hall Ocean City Md</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarct, acute</u> 420.1 } DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>3 Days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, lectory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>10-7-61</u> , to <u>10-7-61</u> , that (I) (we) last saw the deceased alive on <u>10-7-61</u> , and that death occurred at <u>10:30 AM</u> , from the causes and on the date stated above.			
22a. SIGNATURE <u>William R. Ellis, Jr.</u> M.D.		22b. DATE SIGNED <u>10-7-61</u>	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE THEREOF <u>OCT. 9, 1961</u>	23c. NAME OF CEMETERY OR CREMATORY <u>ST. PAULS CHURCH YARD</u>	23d. LOCATION (City, town or county) (State) <u>Berlin Md</u>
24. FUNERAL DIRECTOR'S SIGNATURE <u>Anna A. Burbage</u>		25a. REC'D BY REGISTRAR DATE <u>OCT 11 '61</u>	
ADDRESS <u>Berlin Md</u>		25b. REGISTRAR'S SIGNATURE <u>O. Thur S. Hays</u>	

1800

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M

Mr. J. F. Johnson  
New York  
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1  
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death.

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12023  
12009  
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Wicomico</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>PARSONS BURG</u>	
c. LENGTH OF STAY IN 1b <u>20 mins.</u>		d. STREET ADDRESS	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Peninsula General Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Isaac WARRINGTON HALLAM</u>		4. DATE OF DEATH <u>10 25 1961</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>APRIL 4 1879</u>
9. AGE (In years last birthday) <u>82 yrs.</u>		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED SALESMAN</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>LUMBER</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>NEW CASTLE DELAWARE</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>CHARLES HALLAM</u>		14. MOTHER'S MAIDEN NAME <u>MARY A. BENNER</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>214-10-9131</u>	
17. INFORMANT <u>MRS. AETNA HALLAM, PARSONS BURG, MD</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u> DUE TO <u>4201</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary Atherosclerosis</u> (c) <u>Regenerative Heart Disease</u>		INTERVAL BETWEEN ONSET AND DEATH <u>5-6 hrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Diabetes Mellitus - Insul</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Sept 5</u> to <u>Oct 25</u> , 19 <u>61</u> , that (I) (we) last saw the deceased alive on <u>Sept 5</u> , 19 <u>61</u> , and that death occurred at <u>9</u> A.M., from the causes and on the date stated above.		22a. SIGNATURE <u>William P. Gray</u> M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22b. DATE SIGNED <u>10-25-1961</u>	
22c. PHYSICIAN'S NAME (Type) <u>Dr. William P. Gray</u>		22d. ADDRESS <u>Salisbury, Maryland</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>10/28/61</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>GRACE LAWN CEMETERY</u>		23d. LOCATION (City, town or county) (State) <u>Wilmington, DEL.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>HILL &amp; JOHNSON Co. SALISBURY, Maryland</u>		25a. REC'D BY REGISTRAR <u>Arthur S. Kraus</u>	
25b. REGISTRAR'S SIGNATURE <u>Norman T. Baker</u>		25c. DATE <u>OCT 31 '61</u>	

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Salisbury, Maryland

Dr. William D. Gray

George Washington University

with a view to the study of the

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

12024

12010

<b>1. PLACE OF DEATH</b> a. COUNTY <u>MARYLAND</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u> c. LENGTH OF STAY IN 1b <u>23 X 2</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Peninsula General</u>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Berlin</u> d. STREET ADDRESS <u>N. MAIN ST</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>3. NAME OF DECEASED</b> (Type or print) <u>George Hale Harrison</u>		<b>4. DATE OF DEATH</b> Month <u>October</u> Day <u>9</u> Year <u>1961</u>		<b>5. SEX</b> <u>M</u> <b>6. COLOR OR RACE</b> <u>W</u>			
<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>8. DATE OF BIRTH</b> <u>Nov. 10, 1894</u>		<b>9. AGE</b> (In years last birthday) <u>66</u> yrs. <b>IF UNDER 1 YEAR</b> Months <u>  </u> Days <u>  </u> <b>IF UNDER 24 HRS.</b> Hours <u>  </u> Min. <u>  </u>		<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>GENERAL FARMER</u> <b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>SELF EMPLOYED</u>			
<b>11. BIRTHPLACE</b> (County & State, or foreign country) <u>BERLIN MD</u> <b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.A.</u>		<b>13. FATHER'S NAME</b> <u>Orlando Harrison</u> <b>14. MOTHER'S MAIDEN NAME</b> <u>ADA LONG</u>		<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <u>No</u> <b>16. SOCIAL SECURITY NO.</b> <u>No</u> <b>17. INFORMANT</b> <u>MRS. G. HALE HARRISON</u> Address <u>BERLIN MD</u>			
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arterio sclerotic Heart Disease</u> 4-20-0 DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>  </u> (a), stating the underlying cause last. DUE TO (c) <u>  </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u>							
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH</b> (If either, NOTIFY MEDICAL EXAMINER) <b>20b. DESCRIBE HOW INJURY OCCURED.</b> (Enter nature of injury in Part I or Part II of item 18.) <u>  </u>							
<b>20c. TIME OF INJURY</b> Month, Day, Year <u>  </u> <u>19</u> Hour a.m. <u>  </u> p.m. <u>  </u>		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <u>  </u> <b>20f. (City or town)</b> <u>  </u> (County) <u>  </u> (State) <u>  </u>			
<b>21. I certify</b> that (I) (this hospital) attended the deceased from <u>9-28</u> , 19 <u>61</u> , to <u>10-9</u> , 19 <u>61</u> , that (I) (we) last saw the deceased alive on <u>10-9</u> , 19 <u>61</u> , and that death occurred at <u>4:30</u> M, from the causes and on the date stated above.							
<b>22a. SIGNATURE</b> <u>Willie R. Ellis</u> M.D.				<b>22b. DATE SIGNED</b> <u>10-9-61</u>			
<b>22c. PHYSICIAN'S NAME</b> (Type) <u>  </u>				<b>22d. ADDRESS</b> <u>  </u>			
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>BURIAL</u>		<b>23b. DATE THEREOF</b> <u>10/11/61</u>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>EVERGREEN</u>			
<b>23d. LOCATION</b> (City, town or county) <u>BERLIN</u> (State) <u>MD</u>		<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Anna A. Burbage</u> ADDRESS <u>Berlin, Md</u>					
<b>25a. REC'D BY REGISTRAR</b> <u>  </u> <b>25b. REGISTRAR'S SIGNATURE</b> <u>Arthur S. Hance</u>		<b>DATE</b> <u>OCT 11 '61</u>					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
 15M 9/60

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*[Faint, mostly illegible text, possibly bleed-through from the reverse side of the page. Some words like "Nov 1951" and "1952" are visible.]*

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/59

12025

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

12011

1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Wicomico</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>218 Linwood Ave</b>		d. STREET ADDRESS <b>218 Linwood Ave.</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>CEIVE</b> First <b>BELL</b> Middle <b>HOWARD</b> Last		4. DATE OF DEATH <b>OCTOBER 25th 19 61</b> Month <b>OCTOBER</b> Day <b>25th</b> Year <b>19 61</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Sept. 25, 1879</b>
9. AGE (In years lost birthday) <b>82</b> yrs.		IF UNDER 1 YEAR Months <b>1</b> Days <b>0</b>	IF UNDER 24 HRS. Hours <b></b> Min. <b></b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House Work-Retired</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>	11. BIRTHPLACE (State or foreign country) <b>Crisfield, Maryland</b>
12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>			
13. FATHER'S NAME <b>Isaac Sterling</b>		14. MOTHER'S MAIDEN NAME <b>Unk</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b></b>	
17. INFORMANT <b>Mrs John B. Ball</b> (Address <b>218 Linwood Ave Salisbury, Maryland</b> )			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Fastid intestinal hemorrhage</b> 170X DUE TO <b>Carcinoma of breast &amp; widespread metastases</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO (c) <b></b>		INTERVAL BETWEEN ONSET AND DEATH <b>18 mos.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b></b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <b>N/A</b>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>N/A</b>	
20c. TIME OF INJURY Month, Day, Year Hour o. m. <b>N/A</b> 19 <b>61</b> p. m. <b></b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>N/A</b>		20f. (City or town) <b>N/A</b> (County) <b></b> (State) <b></b>	
21. I certify that (I) (this hospital) attended the deceased from <b>6/15 1961</b> to <b>10/24 1961</b> , that (I) (we) last saw the deceased alive on <b>10/25 1961</b> , and that death occurred at <b>3:40 A.M.</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>Earl M. Beardsley</b>		22b. DATE SIGNED <b>Oct. 26, 1961</b>	
22c. PHYSICIAN'S NAME (Type) <b>Dr. Earl M/Beardsley</b>		22d. ADDRESS <b>Maryland Ave. Salisbury, Maryland</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>10/27/61</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Groton Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Mappville, Virginia</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>HOLLOWAY &amp; COMPANY</b>		ADDRESS <b>SALISBURY MARYLAND</b>	
25a. REC'D BY REGISTRAR <b>OCT 30 '61</b>		25b. REGISTRAR'S SIGNATURE <b>William E. House</b>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1, 2, 3, 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completed, it shall be filed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

12026

## CERTIFICATE OF DEATH

12012

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Wicomico</u> <b>MARYLAND</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SALISBURY</u> c. LENGTH OF STAY in lb <u>5 DAYS</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>PENINSULA General Hospital</u>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Wicomico</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>12 SALISBURY</u> d. STREET ADDRESS <u>101 HIGH ST.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>3. NAME OF DECEASED</b> (Type or print) <u>Nettie Mitchell Johnson</u>		<b>4. DATE OF DEATH</b> Month <u>October</u> Day <u>15</u> Year <u>1961</u>					
<b>5. SEX</b> <u>FEMALE</u>	<b>6. COLOR OR RACE</b> <u>White</u>	<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>WIDOWED</b> <input checked="" type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <u>Nov. 14, 1873</u>	<b>9. AGE</b> (In years last birthday) <u>87</u> yrs.	<b>IF UNDER 1 YEAR</b> Months <u>8</u> Days <u>15</u> <b>IF UNDER 24 HRS.</b> Hours <u>15</u> Min. <u>00</u>		
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>HOUSE WIFE</u>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>OWN HOME</u>		<b>11. BIRTHPLACE</b> (County & State, or foreign country) <u>MARYLAND</u>			
<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.A.</u>							
<b>13. FATHER'S NAME</b> <u>Wm Thomas Mitchell</u>		<b>14. MOTHER'S MAIDEN NAME</b> <u>SARAH ELLEN WHITE</u>					
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <u>NO</u> (If yes give year and dates of service)		<b>16. SOCIAL SECURITY NO.</b> <u>NONE</u>		<b>17. INFORMANT</b> <u>S. Q. JOHNSON, JR.</u> Address <u>SALISBURY, MD.</u>			
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <u>332X</u> DUE TO <u>Cerebral Thrombosis resulting in Left Hemiplegia.</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO <u>Hypertensive Vascular Disease many years</u> DUE TO <u>Generalized Arteriosclerosis many years.</u>							
<b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(e)</b> <u>Myocardial Insufficiency</u>							
<b>20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)					
<b>20c. TIME OF INJURY</b> Month, Day, Year <u>July 19, 1961</u> Hour a.m. <u>19</u> p.m. <u>19</u>		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)			
<b>20f. (City or town)</b> <u>Salisbury, Md.</u>		<b>(County)</b>		<b>(State)</b>			
<b>21. I certify that (I) (this hospital) attended the deceased from <u>July 19, 1961</u> to <u>Oct. 15, 1961</u>, that (I) <u>was</u> last saw the deceased alive on <u>Oct. 15, 1961</u>, and that death occurred at <u>11:50 A.M.</u> from the causes and on the date stated above.</b>							
<b>22a. SIGNATURE</b> <u>Paul G. Cayaves</u> M.D.		<b>ATTENDING PHYS.</b> <input checked="" type="checkbox"/> <b>MED. DIRECTOR</b> <input type="checkbox"/> <b>STAFF PHYS.</b> <input type="checkbox"/>		<b>22b. DATE SIGNED</b> <u>10-15-61</u>			
<b>22c. PHYSICIAN'S NAME (Type)</b> <u>PAUL G. CAYAVES</u>		<b>22d. ADDRESS</b> <u>Salisbury, Md.</u>					
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>BURIAL</u>		<b>23b. DATE THEREOF</b> <u>10/17/1961</u>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>PARSONS CEMETERY</u>			
<b>23d. LOCATION</b> (City, town or county) <u>SALISBURY, MD.</u>		<b>(State)</b>					
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Will Johnson</u>		<b>ADDRESS</b> <u>SALISBURY, MD.</u>		<b>25a. REC'D BY REGISTRAR</b> <u>Oct 17 '61</u>			
<b>25b. REGISTRAR'S SIGNATURE</b> <u>Arthur S. Thomas</u>							

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# 1 FOR STATE HEALTH DEPT.

TO DEPT. OF MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If an agent is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the Medical Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH											
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> <b>MARYLAND</b>						2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <b>Delaware</b> <b>Sussex</b> b. COUNTY <b>Sussex</b>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>						c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Delmar</b>					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Peninsula General Hospital</b>						d. STREET ADDRESS <b>104 Delaware Ave.</b>					
3. NAME OF DECEASED (Type or print) <b>Nina Belle Keefer</b>						4. DATE OF DEATH <b>10-3-61</b>					
5. SEX <b>F</b>		6. COLOR OR RACE <b>W</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Aug 28-1909</b>		9. AGE (In years last birthday) <b>52</b> yrs.		10. IF UNDER 1 YEAR Months Days	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Nurse</b>						10b. KIND OF BUSINESS OR INDUSTRY					
11. BIRTHPLACE (State or foreign country) <b>Delmar, Del.</b>						12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>					
13. FATHER'S NAME <b>Charles Hutchinson</b>						14. MOTHER'S MAIDEN NAME <b>Rosa Parker</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>						16. SOCIAL SECURITY NO. <b>217-30-8042</b>					
17. INFORMANT <b>Earl Keefer, Delmar, Del.</b>						Address					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)											
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Bullet wound of brain</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Sudden</b> DUE TO (c)											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Shot self through head with a pistol.</b>					
20c. TIME OF INJURY Month, Day, Year <b>1:30 P.M. 10-3-61</b>						20d. INJURY OCCURRED While <input type="checkbox"/> at work <input checked="" type="checkbox"/> Not While <input type="checkbox"/> at work <input checked="" type="checkbox"/>					
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Own home.</b>						20f. (City or town) <b>Delmar</b> (County) <b>Sussex</b> (State) <b>Del.</b>					
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE <b>Earl L. Royer, M.D.</b>						CHIEF MEDICAL EXAMINER <input type="checkbox"/>					
EXAMINER'S NAME (Type) <b>Earl L. Royer, M.D.</b>						DATE SIGNED <b>10-5-61</b>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>						22b. DATE THEREOF <b>10-5-61</b>					
22c. NAME OF CEMETERY OR CREMATORY <b>Parsons Cemetery</b>						22d. LOCATION (City, town, or country) (State) <b>Salisbury, Md.</b>					
23. FUNERAL DIRECTOR <b>W.S. Marvel Co.</b>						24a. REC'D BY REGISTRAR <b>Delmar, Del.</b>					
24b. REGISTRAR'S SIGNATURE <b>Arthur S. K...</b>						DATE <b>OCT 9 '61</b>					



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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

12014

1. PLACE OF DEATH o. COUNTY <b>Wicomico</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Wicomico</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>209 Marshall St</b>				d. STREET ADDRESS <b>209 Marshall St</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <b>LULA</b> Middle <b>MAE</b> Last <b>LITTLETON</b>				4. DATE OF DEATH Month <b>October</b> Day <b>17th</b> Year <b>1961</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>April 19, 1880</b>	
9. AGE (In years last birthday) <b>81</b> yrs.		IF UNDER 1 YEAR Months <b>81</b> Days <b>81</b> Hours <b>81</b> Min.		IF UNDER 24 HRS. Months <b>81</b> Days <b>81</b> Hours <b>81</b> Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House Work at Home</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>		11. BIRTHPLACE (State or foreign country) <b>Wicomico County, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>	
13. FATHER'S NAME <b>Edward Lowe</b>				14. MOTHER'S MAIDEN NAME <b>Clara Messick</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>(If yes, give war or dates of service)</b>		17. INFORMANT <b>Mrs. Beatrice L. Davis (Daughter) 209 Marshall St. Salisbury, Maryland</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial infarction</b> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>420.1</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>prev. Myocardial infarction</b>						INTERVAL BETWEEN ONSET AND DEATH <b>56 hrs.</b>	
20a. ACCIDENT WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) <b>N/A</b>					
20c. TIME OF INJURY Month, Day, Year Hour o. m. <b>N/A</b> p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>N/A</b>		20f. (City or town) (County) (State) <b>N/A</b>	
21. I certify that (I) (this hospital) attended the deceased from <b>June 16, 1961</b> to <b>Oct 17, 1961</b> , that (I) (we) last saw the deceased alive on <b>Oct 16, 1961</b> , and that death occurred at <b>5P</b> M, from the causes and on the date stated above.							
22a. SIGNATURE <b>Dr. Earl L. Beardsley</b>				22b. DATE SIGNED <b>Oct. 18/1961</b>			
22c. PHYSICIAN'S NAME (Type) <b>Dr. Earl L. Beardsley</b>				22d. ADDRESS <b>Maryland Ave. Salisbury, Maryland</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Oct. 20, 1961</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Parsons Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Salisbury, Maryland</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>HOLLOWAY &amp; COMPANY</b>				ADDRESS <b>SALISBURY, MARYLAND</b>		25a. REC'D BY REGISTRAR <b>OCT 19 '61</b>	
				25b. REGISTRAR'S SIGNATURE <b>Arthur L. Hume</b>			





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH  
12015

1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Somerset</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>		c. LENGTH OF STAY IN 1b <b>8 yrs.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>John B. Parsons Home for Aged</b>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Linnie</b> Middle <b>(None)</b> Last <b>Lloyd</b>		4. DATE OF DEATH Month <b>October</b> Day <b>26</b> Year <b>19 61</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>April 8, 1877</b>
9. AGE (In years last birthday) <b>84</b> yrs.		10. IF UNDER 1 YEAR Months <b>12</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b>	
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>at home</b>		11b. KIND OF BUSINESS OR INDUSTRY <b>at home</b>	
11c. BIRTHPLACE (State or foreign country) <b>Maryland</b>		11d. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Jacob Jones</b>		14. MOTHER'S MAIDEN NAME <b>Susan Bloodsworth</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>none</b>	
17. INFORMANT <b>Records- John B. Parsons Home for Aged</b>		Address <b>Salisbury, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>600.0</b> DUE TO <b>Pneumonia</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Pyelonephritis</b> DUE TO <b>Pyelonephritis</b> (c) <b>Exhaustion</b>		INTERVAL BETWEEN ONSET AND DEATH <b>12 hrs.</b> <b>1 yr.</b> <b>2 yrs.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> at work Nat while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <b>(1)</b> (this hospital) attended the deceased from <b>Dec 10, 1955</b> to <b>10/26, 1961</b> , that <b>(1)</b> (we) last saw the deceased alive on <b>10/26, 1961</b> , and that death occurred at <b>2:30 PM</b> , from the causes and on the date stated above.			
22a. SIGNATURE <b>W. B. Smith</b>		22b. DATE <b>10/26/61</b>	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS	
23a. BURIAL, CREMATION, REINTERMENT (Type) <b>Burial</b>		23b. DATE THEREOF <b>10/28/1961</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Grace Epis. Church Cem.</b>		23d. LOCATION (City, town, or county) (State) <b>Mt. Vernon Maryland</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Thomas F. Sullivan</b> ADDRESS <b>Salisbury, Md.</b>		25a. REC'D BY REGISTRAR DATE <b>OCT 30 '61</b>	
25b. REGISTRAR'S SIGNATURE <b>Arthur L. Harris</b>			

DEATH CERTIFICATE

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>SALISBURY</u> c. LENGTH OF STAY IN 1b <u>4 Days</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>PENINSULA General Hospital</u>		2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Wicomico</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>X Nantuxke</u> d. STREET ADDRESS <u>1</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>WALTER HUSTON LONG</u>		4. DATE OF DEATH Month <u>October</u> Day <u>28</u> Year <u>1961</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9/27/1907</u>
9. AGE (In years last birthday) <u>54</u> yrs.		10. IF UNDER 1 YEAR Months <u>5</u> Days <u>1</u> Hours <u>0</u> Min. <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Plumber</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Virginia</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>V. S.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Walter Long, Sr.</u>		14. MOTHER'S MAIDEN NAME <u>Maudie Parks</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>217-10-2085</u>	
17. INFORMANT <u>Arthur S. Kneass</u>		Address <u>Salisbury, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>RUPTURED ANEURYSM - ABDOMINAL AORTA</u> DUE TO <u>451X</u> Conditions, if any, which gave rise to immediate cause (b) <u>ARTERIOSCLEROTIC AORTIC ANEURYSM</u> (c) <u>ARTERIOSCLEROTIC AORTIC ANEURYSM</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) INTERVAL BETWEEN ONSET AND DEATH <u>SUDDEN</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>10</u> p.m. <u>24</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>10-24</u> , 19 <u>61</u> , to <u>10-28</u> , 19 <u>61</u> , that (I) <u>(no)</u> last saw the deceased alive on <u>10-27</u> , 19 <u>61</u> , and that death occurred at <u>7:20</u> A.M. from the causes and on the date stated above.			
22a. SIGNATURE <u>Arthur S. Kneass</u>		22b. DATE SIGNED <u>10-28-1961</u>	
22c. PHYSICIAN'S NAME (Type) <u>Salisbury, Md.</u>		22d. ADDRESS <u>Salisbury, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>10/31/61</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Turners Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Nantuxke, Maryland</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Arthur S. Kneass</u>		24b. ADDRESS <u>Baltimore, Md.</u>	
25a. REC'D BY REGISTRAR <u>Arthur S. Kneass</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kneass</u>	
DATE <u>OCT 31 '61</u>			

POST

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
12031  
CERTIFICATE OF DEATH  
12017

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SALISBURY</u> c. LENGTH OF STAY IN 1b <u>3 Days</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>PENINSULA General Hospital</u>		2. USUAL RESIDENCE (Where deceased lived, If institution; Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Wicomico</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>12 Salisbury</u> d. STREET ADDRESS <u>1508 Douglas Rd</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>JAMES EDWARD LOWE</u> First Middle Last 4. DATE OF DEATH <u>October 29, 1961</u> Month Day Year		5. SEX <u>MALE</u> 6. COLOR OR RACE <u>White</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH <u>Dec. 18, 1892</u> 9. AGE (In years last birthday) <u>68</u> yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Ret. ENGINEER</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>Oil BUSINESS</u> 11. BIRTHPLACE (County & State, or foreign country) <u>MARYLAND</u> 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>JAMES E. LOWE Sr</u> 14. MOTHER'S MAIDEN NAME <u>EMMA ANDERSON</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give year or dates of service) 16. SOCIAL SECURITY NO. <u>—</u> 17. INFORMANT <u>MRS. KATHERINE H. LOWE, Same</u> Address		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <u>420.1</u> IMMEDIATE CAUSE (a) <u>Coronary Artery Thrombosis</u> DUE TO (b) <u>1 day</u> Conditions, if any, which gave rise to immediate cause (c) <u>1 day</u> (e), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <u>Chronic Bronchitis; Pulmonary Emphysema</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II, item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21. I certify that (I) (this hospital) attended the deceased from <u>Oct 28, 1961</u> to <u>Oct 29, 1961</u> , that (I) (we) last saw the deceased alive on <u>Oct 28, 1961</u> , and the death occurred at <u>7:45</u> A.M. from the causes and on the date stated above.		22a. SIGNATURE <u>David J. Gilmore</u> M.D. 22b. DATE SIGNED <u>10-30-61</u> 22c. PHYSICIAN'S NAME (Type) <u>DAVID J. Gilmore</u> 22d. ADDRESS <u>Salisbury, Maryland</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u> 23b. DATE THEREOF <u>10-31-1961</u> 23c. NAME OF CEMETERY OR CREMATORY <u>PARSONS Cemetery</u> 23d. LOCATION (City, town or county) (State) <u>SALISBURY, MARYLAND</u>		24. FUNERAL DIRECTOR'S SIGNATURE <u>Hill &amp; Johnson</u> ADDRESS <u>Salisbury, MD.</u> 25. REC'D BY REGISTRAR <u>OCT 31 '61</u> 25b. REGISTRAR'S SIGNATURE <u>Arthur S. Harris</u>	

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James L. Jones

Oct 21 1903

John L. Jones

Oct 21 1903



# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

12032

12018

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Wicomico</u> <span style="float: right;">MARYLAND</span> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u> c. LENGTH OF STAY IN 1b <u>23 years</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Peninsula General Hosp. Tal</u>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution: Residence before admission) e. STATE <u>Maryland</u> <span style="float: right;">b. COUNTY <u>Wicomico</u></span> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u> d. STREET ADDRESS <u>Woodland Road</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>3. NAME OF DECEASED</b> (Type or print) <u>Marvin P. Lyons</u>		<b>4. DATE OF DEATH</b> Month <u>10</u> Day <u>1</u> Year <u>1961</u>		<b>5. SEX</b> <u>Male</u> <b>6. COLOR OR RACE</b> <u>White</u> <b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			
<b>8. DATE OF BIRTH</b> <u>12-21-02</u> <b>9. AGE</b> (In years last birthday) <u>58</u> yrs. IF UNDER 1 YEAR: Months <u>  </u> Days <u>  </u> IF UNDER 24 HRS. Hours <u>  </u> Min. <u>  </u>		<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Salesman</u> <b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>Insurance</u> <b>11. BIRTHPLACE</b> (County & State, or foreign country) <u>Cambridge, Md.</u> <b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.A.</u>					
<b>13. FATHER'S NAME</b> <u>Oscar P. Lyons</u> <b>14. MOTHER'S MAIDEN NAME</b> <u>Nora Currey</u>				<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <u>no</u> <b>16. SOCIAL SECURITY NO.</b> <u>214-10-9790</u> <b>17. INFORMANT</b> <u>Mrs. Neita Lyons</u> <u>Salisbury, Md.</u>			
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cornary Thrombosis</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>  </u> (a), stating the underlying cause last. DUE TO (c) <u>  </u>				INTERVAL BETWEEN ONSET AND DEATH <u>  </u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Gastric hemorrhage from duodenal ulcer</u> <b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <b>20c. TIME OF INJURY</b> Month, Day, Year <u>9-28-61</u> Hour a.m. <u>  </u> p.m. <u>19</u>		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.) <b>20d. INJURY OCCURRED</b> While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <u>  </u> <b>20f. (City or town)</b> <u>Salisbury</u> (County) <u>  </u> (State) <u>  </u>			
<b>21. I certify</b> that (I) (this hospital) attended the deceased from <u>9-28-61</u> to <u>10-1-61</u> , that (I) (we) last saw the deceased alive on <u>10-1-61</u> , and that death occurred <u>6:00 P.M.</u> from the causes and on the date stated above.							
<b>22a. SIGNATURE</b> <u>Frederick J. Smith</u> M.D. <b>22c. PHYSICIAN'S NAME</b> (Type) <u>Frederick J. Smith</u>				<b>ATTENDING PHYS.</b> <input checked="" type="checkbox"/> <b>MED. DIRECTOR</b> <input type="checkbox"/> <b>STAFF PHYS.</b> <input type="checkbox"/> <b>22d. ADDRESS</b> <u>  </u> <b>22b. DATE SIGNED</b> <u>10-1-61</u>			
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>Burial</u> <b>23b. DATE THEREOF</b> <u>10-4-61</u>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Dorchester Memorial Park</u> ADDRESS <u>CAMBRIDGE, MD.</u>		<b>23d. LOCATION</b> (City, town or county) <u>Cambridge, Md.</u> (State) <u>  </u>			
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Kenneth R. Thomas</u>				<b>25a. REC'D BY REGISTRAR</b> <u>  </u> <b>25b. REGISTRAR'S SIGNATURE</b> <u>  </u> <b>DATE</b> <u>OCT 5 '61</u>			

M

I

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

18018

11088

M

Missouri

Salisbury

3 years

Woodland Road

1900

R.

Marion

28

12-21-02

White

Male

U.S.A.

Cambridge, Mo.

Inspected

Seizure

Box 1000

Green B. Lyons

Mr. H. H. Jones, Salisbury, Mo.

no

1

*Poste restante*

8-7-09

*Poste restante*

Cambridge, Mo.

Postmaster's Office

12-21-02

White

U.S.A.

Cambridge, Mo.

*Poste restante*

1  
FOR STATE  
HEALTH DEPT.

TO DEPT. OF MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If an agent is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the Medical Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH											
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
12033 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 12019											
1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b> c. LENGTH OF STAY IN 1b <b>D.O.A.</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Peninsula General Hospital</b>						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Wicomico</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b> d. STREET ADDRESS <b>Route #4 Johnson Road</b> e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <b>George Hardy Merrill</b>						4. DATE OF DEATH <b>10-26-61</b>					
5. SEX <b>M</b>		6. COLOR OR RACE <b>W</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>April 11, 1905</b>		9. AGE (In years last birthday) <b>56 yrs.</b>		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farmer</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Broiler</b>				11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>John L. Merrill</b>						14. MOTHER'S MAIDEN NAME <b>Mary Anna Hickman</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>				16. SOCIAL SECURITY NO. <b>220-01-9428</b>		17. INFORMANT <b>Mrs Elsie Merrill, Salisbury, Maryland</b> Address <b>Johnson Road</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)											
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary occlusion</b> 420-0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arterio-sclerotic heart disease.</b> DUE TO INTERVAL BETWEEN ONSET AND DEATH <b>Sudden.</b> Years											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)											
12a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				12b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE <b>Earl L. Royer, M.D.</b>						CHIEF MEDICAL EXAMINER <input type="checkbox"/>					
EXAMINER'S NAME (Type) <b>407 Camden Ave. Salisbury, Md.</b>						ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>					
						DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>						22b. DATE THEREOF <b>10-28-61</b>		22c. NAME OF CEMETERY <b>Salem Methodist</b>		22d. LOCATION (City, town, or country) (State) <b>Pocomoke City, Maryland</b>	
23. FUNERAL DIRECTOR <b>Henry J. Watson</b>						ADDRESS <b>Pocomoke City, Md.</b>		24a. REC'D BY REGISTRAR <b>NOV 1 '61</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur J. Kraus</b>	

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MEDICAL CERTIFICATION

2 JAN 1951

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(T)

12033

Albuquerque

Albuquerque

Albuquerque General Hospital

Albuquerque General Hospital

April 11, 1951

Albuquerque

Albuquerque

Albuquerque General Hospital

Albuquerque General Hospital

10-10-51

Albuquerque General Hospital

Albuquerque General Hospital

Albuquerque

Albuquerque General Hospital

Albuquerque

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

12034

## CERTIFICATE OF DEATH

12020

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Wicomico</u> <span style="float: right;">MARYLAND</span> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>SALISBURY</u> c. LENGTH OF STAY IN 1b <u>1</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>PENINSULA GENERAL HOSPITAL</u>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Wicomico</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Fruitland</u> d. STREET ADDRESS <u>Dulaney Ave.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>3. NAME OF DECEASED</b> (Type or print) <u>PATRICIA ANN MILES</u>		<b>4. DATE OF DEATH</b> Month <u>OCTOBER</u> Day <u>14</u> Year <u>1961</u>		<b>5. SEX</b> <u>FEMALE</u>			
<b>6. COLOR OR RACE</b> <u>NEGRO</u>		<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> <b>8. DATE OF BIRTH</b> <u>AUGUST 2, 1961</u>		<b>9. AGE</b> (In years last birthday) <u>2</u> <b>IF UNDER 1 YEAR</b> Months <u>2</u> Days <u>12</u> <b>IF UNDER 24 HRS.</b> Hours <u></u> Min. <u></u>			
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>NONE</u>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u></u>		<b>11. BIRTHPLACE</b> (County & State, or foreign country) <u>MARYLAND</u>			
<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.A.</u>		<b>13. FATHER'S NAME</b> <u>Wilson L. Miles</u>		<b>14. MOTHER'S MAIDEN NAME</b> <u>Elsie Justice</u>			
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <u></u>		<b>16. SOCIAL SECURITY NO.</b> <u></u>		<b>17. INFORMANT</b> <u>Mrs. Wilson Miles - Fruitland, Md.</u>			
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia</u> DUE TO (b) <u>Congenital Heart Disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u></u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <u>Multiple Congenital Defects including 1) Congenital Cerebral Defect 2) Bilateral cataracts</u>							
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> <b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.) <u></u>							
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour e.m. <u>19</u> p.m. <u></u>		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <u></u>			
<b>20f. (City or town)</b> <u></u>		<b>(County)</b> <u></u>		<b>(State)</b> <u></u>			
<b>21. I certify</b> that (I) (this hospital) attended the deceased from <u>9/25, 1961</u> to <u>10/14, 1961</u> , that (I) (we) last saw the deceased alive on <u>10/14</u> , 19 <u>61</u> , and that death occurred at <u>11:45</u> A.M. from the causes and on the date stated above.							
<b>22a. SIGNATURE</b> <u>Alfred C. Kolls</u> M.D.				<b>22b. DATE SIGNED</b> <u>10/15/61</u>			
<b>22c. PHYSICIAN'S NAME</b> (Type) <u>Alfred C. Kolls</u>				<b>22d. ADDRESS</b> <u>Medical Center Salisbury, Md.</u>			
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>BURIAL</u>		<b>23b. DATE THEREOF</b> <u>10-17-1961</u>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>GREEN ACRE Cem.</u>			
<b>23d. LOCATION</b> (City, town or county) <u>Salisbury, Md.</u>		<b>(State)</b> <u></u>		<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Thornton B. Jolley, Salisbury, Md.</u>			
<b>25a. REC'D BY REGISTRAR</b> DATE <u>OCT 19 1961</u>		<b>25b. REGISTRAR'S SIGNATURE</b> <u>Arthur S. Hines</u>					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1, 2, 3, and 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
 15M 9/60

202192 xv3

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1997



# 1 FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 7/59

## MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Wicomico</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Dr. Kolls office: Medical Center</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Deborah Frances Mills</b>	4. DATE OF DEATH <b>10-6-61</b>	5. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
6. SEX <b>F</b>	7. COLOR OR RACE <b>C</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. AGE (In years last birthday) <b>2</b> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
13. FATHER'S NAME <b>Leon J. Mills</b>	14. MOTHER'S MAIDEN NAME <b>Naoma Corbin</b>	15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	
16. SOCIAL SECURITY NO.	17. INFORMANT <b>Leon Mills 900 East Road Salisbury, Md.</b>	18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Enteritis</b> DUE TO (b) <b>Shigella Dysentery</b> DUE TO (c) <b>12 hours</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: <b>Natural causes</b> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>Earl L. Royer, M.D.</b>	CHIEF MEDICAL EXAMINER <input type="checkbox"/>	ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>
EXAMINER'S NAME (Type) <b>407 Camden Ave. Salisbury, Md.</b>	DATE SIGNED <b>10-11-61</b>		
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>10/ 8/1961</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Church</b>	22d. LOCATION (City, town, or country) (State) <b>Polks Road Md.</b>
23. FUNERAL DIRECTOR <b>Clinton F. Stewart Salisbury, Md.</b>		24a. REC'D BY REGISTRAR <b>OCT 19 '61</b>	24b. REGISTRAR'S SIGNATURE <b>Arthur L. Thomas</b>

M

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10-11-61

107 E. 10th Ave., New York, N.Y.

Mr. J. Edgar Hoover, Director, FBI

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

12036

Items 7 & 9 Film G299 11/7/61 iwk

12022

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>SALISBURY</u> c. LENGTH OF STAY IN 1b. <u>1 YEAR</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>PENINSULA General Hospital</u>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Wicomico</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>X SALISBURY</u> d. STREET ADDRESS <u>1 % W.F. ALLEN FARM</u> e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>EARL MORRIS</u>		4. DATE OF DEATH <u>October 29, 1961</u>					
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>NEGRO</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <u>Separated</u> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>unknown</u>	9. AGE (In years last birthday) <u>55</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <u>unknown</u>			
12. CITIZEN OF WHAT COUNTRY? <u>unknown</u>		13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: <u>442X</u> DUE TO <u>Cardio-Respiratory Complications</u> <u>1. Sudden</u> DUE TO <u>Severe Cerebral Hemorrhage</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					INTERVAL BETWEEN ONSET AND DEATH		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)		
21. I certify that (I) (this hospital) attended the deceased from <u>9/18/61</u> , 19 <u>61</u> , to <u>10/29/61</u> , 19 <u>61</u> , that (I) (we) last saw the deceased alive on <u>10/28/61</u> , 19 <u>61</u> , and that death occurred at <u>8:30</u> M, from the causes and on the date stated above.							
22a. SIGNATURE <u>Carrie Hearn</u> M.D.		ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED			
22c. PHYSICIAN'S NAME (Type or print) <u>CARRIE HEARN</u>		22d. ADDRESS <u>26 W. H. ...</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF <u>10-31-61</u>	23c. NAME OF CEMETERY OR CREMATORY <u>U. of Md. Med. School</u>		23d. LOCATION (City, town or county) (State) <u>Baltimore Md.</u>			
24. FUNERAL DIRECTOR'S SIGNATURE <u>Booker ...</u>		ADDRESS		25a. REC'D BY REGISTRAR DATE <u>NOV 1 '61</u>	25b. REGISTRAR'S SIGNATURE <u>Arthur S. ...</u>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

(M)

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
12037  
CERTIFICATE OF DEATH  
12023

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>SALISBURY</u> c. LENGTH OF STAY IN 1b <u>4 WEEKS</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>PENINSULA GENERAL HOSPITAL</u>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>DELAWARE</u> b. COUNTY <u>SUSSEX</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>SEAFORD</u> RURAL <u>46x-3</u> d. STREET ADDRESS <u>RD #2 SEAFORD-LAUREL HWY</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>HARRY JAMES MULLIN</u> First Middle Last				4. DATE OF DEATH <u>October 26 1961</u> Month Day Year			
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>SEPT 4 1908</u> yrs. Months Days		9. AGE (In years last birthday) <u>53</u> yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>CARPENTER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>BUILDING CONST.</u>		11. BIRTHPLACE (County & State, or foreign country) <u>DELAWARE</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>JAMES A. MULLIN</u>			14. MOTHER'S MAIDEN NAME <u>VERDIE MESSICK</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>221-07-8606</u>		17. INFORMANT <u>GERTRUDE LYND MULLIN</u> Address <u>RD #2 SEAFORD, DELAWARE</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARCINOMA BLADDER</u> <u>181.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) _____ (a), stating the underlying cause last. } DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH <u>2 YRS</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) _____	
20c. TIME OF INJURY Hour a.m. _____ p.m. _____ Month, Day, Year _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that (I) (this hospital) attended the deceased from <u>9/27 1961</u> to <u>10/26 1961</u> , that (I) (we) last saw the deceased alive on <u>10/26 1961</u> , and that death occurred at <u>10:45</u> A.M. from the causes and on the date stated above.							
22a. SIGNATURE <u>John M. Bloxom Jr</u> M.D.			ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED <u>10/26/1961</u>		
22c. PHYSICIAN'S NAME (Type) <u>JOHN M. BLOXOM JR</u>			22d. ADDRESS <u>MEDICAL CENTER, SALISBURY, MD</u>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>OCT 28, 1961</u>		23c. NAME OF CEMETERY OR CREMATORY <u>ODD FELLOWS CEM.</u>		23d. LOCATION (City, town or county) <u>SEAFORD, DELAWARE</u> (State) _____	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Rayner M. Watson</u>			ADDRESS <u>SEAFORD, DEL.</u>		25a. REC'D BY REGISTRAR <u>OCT 30 '61</u> DATE		
					25b. REGISTRAR'S SIGNATURE <u>Arthur L. Kraus</u>		

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

12038

12024

<b>1. PLACE OF DEATH</b> a. COUNTY <b>Wicomico</b> <b>MARYLAND</b>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, if Institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Queen Anne's</b>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>				c. LENGTH OF STAY IN 1b <b>60 days</b>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Deer's Head</b>				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Centreville</b>			
d. STREET ADDRESS <b>120 Kidwell Ave</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>3. NAME OF DECEASED</b> (Type or print) <b>Mary</b>		<b>First</b> <b>Eliza</b>		<b>Last</b> <b>Pinder</b>		<b>4. DATE OF DEATH</b> Month <b>October</b> Day <b>27</b> Year <b>19 61</b>	
<b>5. SEX</b> <b>Female</b>		<b>6. COLOR OR RACE</b> <b>White</b>		<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <b>JULY 27-1890</b>	
<b>9. AGE</b> (In years last birthday) <b>71 yrs.</b>		<b>10. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		<b>11. BIRTHPLACE</b> (County & State, or foreign country) <b>Rock Hall Maryland</b>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>USA</b>	
<b>13. FATHER'S NAME</b> <b>Charles O Kendall</b>				<b>14. MOTHER'S MAIDEN NAME</b> <b>Florence A Dadds</b>			
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <b>no</b> (If yes give war or dates of service)				<b>16. SOCIAL SECURITY NO.</b> <b>217-03-5772</b>		<b>17. INFORMANT</b> <b>John W Pinder</b> Address <b>Centreville Maryland</b>	
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Recurrent cerebral thrombosis</b> <b>443X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Hypertensive arteriosclerotic cardiovascular disease</b> DUE TO (c) <b>disease</b>						INTERVAL BETWEEN ONSET AND DEATH <b>3 days</b> <b>Years</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Diabetes mellitus</b>						<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (If either, notify medical examiner)		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)					
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. p.m. <b>19</b>		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town)</b> (County) (State)	
<b>21. I certify that (I) (this hospital) attended the deceased from August 28, 1961 to October 27, 1961, that (I) (we) last saw the deceased alive on October 26, 1961, and that death occurred at 12:40 A.M. from the causes and on the date stated above.</b>							
<b>22a. SIGNATURE</b> <b>L. V. Maldve, M. D.</b>				<b>22b. DATE SIGNED</b> <b>10/27/61</b>		<b>22c. PHYSICIAN'S NAME</b> (Type) <b>L. V. Maldve, M. D.</b>	
<b>22d. ADDRESS</b> <b>Deer's Head Hospital; Salisbury, Md.</b>				<b>22e. REC'D BY REGISTRAR</b> <b>NOV 2 '61</b>			
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <b>Burial</b>		<b>23b. DATE THEREOF</b> <b>Oct 30. 61</b>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <b>Chesterfield</b>		<b>23d. LOCATION</b> (City, town or county) (State) <b>Centreville Maryland</b>	
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <b>W. E. ...</b>				<b>25a. REGISTRAR'S SIGNATURE</b> <b>...</b>			



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# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

12039

## CERTIFICATE OF DEATH

12025

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Wicomico</u> <span style="float: right;">MARYLAND</span> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u> c. LENGTH OF STAY IN 1b <u>1 day</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Peninsula General Hospital</u>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) e. STATE <u>Maryland</u> b. COUNTY <u>Dorchester</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Rhodesdale</u> d. STREET ADDRESS <u>R.F.D.</u>			
<b>3. NAME OF DECEASED</b> (Type or print) <u>Henrietta Sampson</u> First Middle Last		<b>4. DATE OF DEATH</b> <u>October 21 - 1961</u> Month Day Year		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>5. SEX</b> <u>Female</u>		<b>6. COLOR OR RACE</b> <u>Colored</u>		<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>8. DATE OF BIRTH</b> <u>June 1, 1908</u> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			
<b>9. AGE</b> (In years last birthday) <u>53 yrs.</u>		<b>10. KIND OF BUSINESS OR INDUSTRY</b> <u>Housework</u>		<b>11. BIRTHPLACE</b> (County & State, or foreign country) <u>Dorchester Co., Maryland</u>			
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired)		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.A.</u>		<b>14. MOTHER'S MAIDEN NAME</b> <u>Margaret Manoky</u>			
<b>13. FATHER'S NAME</b> <u>David Jones</u>				<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <u>No</u>			
<b>16. SOCIAL SECURITY NO.</b> <u>Unknown</u>		<b>17. INFORMANT</b> <u>David Jones, Rhodesdale, Maryland, RFD</u>					
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Vascular Accident</u> (b) <u>Diabetes Mellitus</u> (c) <u>Spinal Cord (St. Bleeding)</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)							
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. p.m. <u>19</u>		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)			
<b>20f. (City or town)</b>		<b>(County)</b>		<b>(State)</b>			
<b>21. I certify that (I) (this hospital) attended the deceased from</b> <u>10-20-1961</u> , to <u>10-21-1961</u> , that (I) (we) last saw the deceased alive on <u>10-21-1961</u> , and that death occurred at <u>10:30</u> M., from the causes and on the date stated above.							
<b>22a. SIGNATURE</b> <u>H. A. Briele</u>				<b>22b. DATE SIGNED</b> <u>10-23-61</u>			
<b>22c. PHYSICIAN'S NAME</b> (Type) <u>H. A. Briele</u>				<b>22d. ADDRESS</b> <u>Medical Center Salisbury, Md</u>			
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>Burial</u>		<b>23b. DATE THEREOF</b> <u>Oct. 26, 1961</u>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>East New Market Cemetery</u>			
<b>23d. LOCATION</b> (City, town or county) <u>East New Market, Maryland</u>		<b>(State)</b>					
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <u>J. J. Framptom and Son, Federalburg, Maryland</u>				<b>25a. REC'D BY REGISTRAR</b> <u>OCT 30 '61</u>			
<b>25b. REGISTRAR'S SIGNATURE</b> <u>Arthur S. Kraus</u>				<b>DATE</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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United States  
William Miller  
San Francisco (Cal. 1840)

Miller  
San Francisco

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# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

12040

## CERTIFICATE OF DEATH

12026

1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> <b>MARYLAND</b>			2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Wicomico</b>		
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>			c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Quantico</b>		
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Peninsula General Hospital</b>			d. STREET ADDRESS <b>Box# 26</b>		
3. NAME OF DECEASED (Type or print) <b>MARGARET LOUISE SENKBEIL</b>			4. DATE OF DEATH <b>October 17 1961</b>		
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Mar. 25, 1913</b>		9. AGE (In years last birthday) <b>48</b> yrs.
10e. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House Work at Home</b>			11. BIRTHPLACE (County & State, or foreign country) <b>Bellaire, Ohio</b>		12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>
13. FATHER'S NAME <b>Alouis Habenicht</b>			14. MOTHER'S MAIDEN NAME <b>Margaret L. Callairi</b>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <b>No</b>			16. SOCIAL SECURITY NO. <b>Mr. Wm. Henry Senkbeil (Husband) Box# 26 Quantico, Maryland</b>		
18. CAUSE OF DEATH [Enter only one cause for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Glioblastoma multiforme</b> <b>1934</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <b>with intracerebral extension</b> DUE TO (c)					INTERVAL BETWEEN ONSET AND DEATH <b>5 mos.</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <b>N/A</b>			20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) <b>N/A</b>		
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>N/A</b> 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>N/A</b>	
20f. (City or town) <b>N/A</b>		20g. (County) <b>N/A</b>		20h. (State) <b>N/A</b>	
21. I certify that (I) (this hospital) attended the deceased from <b>April 1st 1961</b> to <b>Oct. 7, 1961</b> , that (I) (we) last saw the deceased alive on <b>Oct. 1, 1961</b> , and that death occurred at <b>11:00 P.M.</b> from the causes and on the date stated above.					
22a. SIGNATURE <b>Dr. Earl M. Beardsley</b>			22b. DATE SIGNED <b>10/17/61</b>		
22c. PHYSICIAN'S NAME (Type) <b>Dr. Earl M. Beardsley</b>			22d. ADDRESS <b>Maryland Ave. Salisbury, Maryland</b>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Oct. 20, 1961</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Wicomico Memorial Park</b>	
23d. LOCATION (City, town or county) <b>Salisbury, Maryland</b>		23e. (State) <b>Maryland</b>		23f. (Country) <b>U.S.A.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>HOLLOWAY &amp; COMPANY - SALISBURY MARYLAND</b>			25a. REC'D BY REGISTRAR <b>DATE OCT 19 '61</b>		
25b. REGISTRAR'S SIGNATURE <b>Arthur L. Howard</b>			25c. (State) <b>Maryland</b>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1, 2, 3, 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
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MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
CERTIFICATE OF DEATH									
1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b> c. LENGTH OF STAY IN 1b <b>84 days</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Deer's Head State Hospital</b>					2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Dorchester</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Church Creek</b> d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) <b>Robert Franklin Stanley</b>			4. DATE OF DEATH <b>October 10 1961</b>						
5. SEX <b>Male</b>		6. COLOR OR RACE <b>Colored</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>March 16, 1886</b>		9. AGE (In years last birthday) <b>75</b> yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>			10b. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (County & State, or foreign country) <b>Dorchester County</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Robert Stanley</b>			14. MOTHER'S MAIDEN NAME <b>Margaret Bazzle</b>			15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes give war or dates of service) <b>220-05-3378</b>			
16. SOCIAL SECURITY NO. <b>220-05-3378</b>			17. INFORMANT <b>Margie Mays</b>			Address <b>2115 W. Fayette Balti., Md.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Metastatic carcinoma of lungs, bilateral</b> DUE TO (b) <b>Adenocarcinoma of right neck</b> DUE TO (c) <b>Arteriosclerotic cardiovascular disease</b> CONDITIONS, if any, which gave rise to immediate cause (e), stating the underlying cause last.								INTERVAL BETWEEN ONSET AND DEATH <b>?</b> <b>?</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <b>July 18, 1961</b> to <b>Oct. 10, 1961</b> , that (I) (we) last saw the deceased alive on <b>October 9, 1961</b> , and that death occurred at <b>2:15 A.M.</b> M, from the causes and on the date stated above.									
22a. SIGNATURE <b>V. Juerman</b>			M.D. <b>22b. DATE SIGNED 10/10/61</b>		ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>				
22c. PHYSICIAN'S NAME (Type) <b>V. Juerman, M.D.</b>			22d. ADDRESS <b>Deer's Head State Hospital; Salisbury, Md.</b>						
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>10/15/61</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Bucktown</b>		23d. LOCATION (City, town or county) (State) <b>Bucktown Maryland</b>			
24. FUNERAL DIRECTOR'S SIGNATURE <b>Herbert M. Wallace Jr.</b>				ADDRESS <b>Cambridge, Md.</b>		25a. REC'D BY REGISTRAR <b>DATE OCT 26 '61</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur L. Kross</b>	

(M)

(1)

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**MARYLAND STATE DEPARTMENT OF HEALTH**  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

12042

12028

1. PLACE OF DEATH a. COUNTY <u>WILCOMICO</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>WILCOMICO</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SHARPTOWN</u>				c. LENGTH OF STAY IN 1b <u>50 yrs</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>MAIN ST</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>ERMON WILLIAM TAYLOR</u> (First Middle Last)				4. DATE OF DEATH <u>OCT 17</u> 19 <u>61</u> (Month Day Year)			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>DEC 30 1879</u>		9. AGE (In years lost birthday) <u>81</u> yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED GARDENER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>NONE</u>		11. BIRTHPLACE (State or foreign country) <u>MD</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>WILLIAM TAYLOR</u>				14. MOTHER'S MAIDEN NAME <u>AMANDA GRAVENOR</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT <u>MRS WALTER F. COOLING - CHESAPEAKE CITY, MD.</u> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>acute myocardial infarction</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>arteriosclerotic cardiac vascular disease</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE GIVEN IN PART I (a) _____							INTERVAL BETWEEN ONSET AND DEATH _____
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>11/1</u> 19 <u>60</u> to <u>10/17</u> 19 <u>61</u> , that (I) (we) lost saw the deceased alive on <u>10/17</u> 19 <u>61</u> , and that death occurred at _____ M, from the causes and on the date stated above.							
22a. SIGNATURE <u>Charles M. Moyes</u> M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type)				22d. ADDRESS <u>Samuel Hill</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>10-20-61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>FIREMEN'S</u>		23d. LOCATION (City, town, or county) (State) <u>SHARPTOWN MD</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Smith Funeral Home, Sharptown, MD.</u> ADDRESS				25a. REC'D BY REGISTRAR <u>OCT 26 '61</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>	

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

CERTIFICATE OF DEATH

1962

State of Maryland  
County of Prince George's  
I, the undersigned, Clerk of the Circuit Court for the County of Prince George's, do hereby certify that the within and foregoing is a true and correct copy of the original of the same as the same appears from the records of the said Court.

Witness my hand and the seal of the said Court at the City of Alexandria, Virginia, this 11th day of June, 1962.

1  
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
12043  
12029  
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Wicomico</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>506 Anne St</b>				d. STREET ADDRESS <b>506 Anne St</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <b>HARLEY</b> Middle <b>LEE</b> Last <b>TINGLE</b>				4. DATE OF DEATH Month <b>OCTOBER</b> Day <b>21st</b> Year <b>19 61</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Oct. 31, 1886</b>	
9. AGE (In years last birthday) <b>74</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Employee at Lumber Mill (Laborer)</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Mill (Laborer)</b>		11. BIRTHPLACE (State or foreign country) <b>Melson, Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>							
13. FATHER'S NAME <b>Elisha W. Tingle</b>				14. MOTHER'S MAIDEN NAME <b>Viola Figgs</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>				16. SOCIAL SECURITY NO. <b>(If yes, give war or dates of service)</b>			
17. INFORMANT <b>Mr. Melvin E. Tingle (Son) Danascus, Md.</b> <b>Mrs. Pearl Q. Tingle (Wife) - Address Above</b>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinoma of liver</b> DUE TO <b>156.1</b> Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause last. (b) <b>6 mo.</b> (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Chronic bronchitis - arteriosclerotic heart dis.</b>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>N/A</b>			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>N/A</b> p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>N/A</b>				20f. (City or town) <b>N/A</b> (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <b>Oct 21 1961</b> to <b>Oct 21 1961</b> , that (I) (we) lost saw the deceased alive on <b>Oct 21 1961</b> , and that death occurred at <b>4:30 P.M.</b> from the causes and on the date stated above.							
22a. SIGNATURE <b>L.V. Sohler</b>				22b. DATE SIGNED <b>Oct. 23 /1961</b>			
22c. PHYSICIAN'S NAME (Type) <b>Dr. L.V. Sohler</b>				22d. ADDRESS <b>Delmar, Maryland</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Oct. 24, 1961</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Melson Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>R.D.# Delmar, Maryland</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>HOLLOWAY &amp; COMPANY</b> ADDRESS <b>SALISBURY MARYLAND</b>				25a. REC'D BY REGISTRAR <b>Oct 24 61</b> DATE		25b. REGISTRAR'S SIGNATURE <b>Arthur L. Hume</b>	

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## CERTIFICATE OF DEATH

Reg. Dist. No.

12030

1. PLACE OF DEATH a. COUNTY <b>Wicomico</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Wicomico</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>		c. LENGTH OF STAY IN lb <b>15 Mos.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Spring Hill Private Sanitarium</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>ALICE NMI TOADVINE</b>		4. DATE OF DEATH Month Day Year <b>October 15 1961</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Jan. 26, 1878</b>
9. AGE (In years last birthday) <b>83</b>		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired School Teacher</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Maryland</b>	
11. BIRTHPLACE (State or foreign country) <b>U. S. A.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Stephen P. Toadvine</b>		14. MOTHER'S MAIDEN NAME <b>Martha Ruark</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>Henry H. Hannah Jr.</b>		Address <b>Woodland Rd, Salisbury, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic Heart Disease</b> <b>420.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>9-10</b> , 19 <b>58</b> , to <b>10-15</b> , 19 <b>61</b> , that I last saw the deceased alive on <b>10-15</b> , 19 <b>61</b> , and that death occurred at <b>2 P.M.</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Wilbur R. Ellis Jr.</b>		ADDRESS (Street, city or town, state) <b>Salisbury, Md.</b> DATE SIGNED <b>10-16-61</b>	
PHYSICIAN'S NAME (Type) <b>Wilbur R. Ellis Jr.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>10-16-61</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Parsons Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Salisbury, Maryland</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>HILL &amp; JOHNSON FUNERAL HOME, Salisbury, Md.</b>		24a. REC'D BY REGISTRAR DATE <b>OCT 17 '61</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur S. Hume</b>			

Page 4 after death. The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death.

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CERTIFICATE OF DEATH

STATE OF NEW YORK

1910

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# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

12045

12031

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Wicomico</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u> c. LENGTH OF STAY IN 1b <u>MARYLAND</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Peninsula General Hospital</u>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u> d. STREET ADDRESS <u>302 Blvd. (north)</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>3. NAME OF DECEASED</b> (Type or print) <u>ALBERT EDISON</u>				<b>4. DATE OF DEATH</b> Month <u>October</u> Day <u>12</u> Year <u>1961</u>			
<b>5. SEX</b> <u>male</u>		<b>6. COLOR OR RACE</b> <u>white</u>		<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <u>Dec. 7, 1910</u>	
<b>9. AGE</b> (In years last birthday) <u>50</u> yrs.		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u>		IF UNDER 24 HRS. Hours <u>  </u> Min. <u>  </u>		<b>10. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Asst Manager (Eastside Men's Club)</u>	
<b>11. BIRTHPLACE</b> (County & State, or foreign country) <u>Pittsville, Maryland</u>				<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U S A</u>			
<b>13. FATHER'S NAME</b> <u>Levin T. Truitt</u>				<b>14. MOTHER'S MAIDEN NAME</b> <u>Emma Johnson</u>			
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <u>YES</u> <u>W.W.#11</u>				<b>16. SOCIAL SECURITY NO.</b> <u>  </u>			
<b>17. INFORMANT</b> <u>Mrs. Rose Olive Truitt (Wife)</u>				Address <u>302 N. Blvd. Salisbury, Maryland</u>			
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial infarction</u> DUE TO (b) <u>Coronary Artery Disease</u> DUE TO (c) <u>  </u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>  </u>						INTERVAL BETWEEN ONSET AND DEATH <u>17 days</u> <u>?</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <u>Pneumonia</u>						<b>19. WAS AUTOPSY PERFORMED?</b> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <u>N/A</u>				<b>20b. DESCRIBE HOW INJURY OCCURED.</b> (Enter nature of injury in Part I or Part II of item 18.) <u>  </u>			
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. <u>  </u> p.m. <u>  </u> <u>N/A</u> <u>19</u>		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <u>N/A</u>		<b>20f. (City or town)</b> <u>N/A</u>	
<b>20g. (County)</b> <u>  </u>		<b>20h. (State)</b> <u>  </u>		<b>21. I certify that (I) (this hospital) attended the deceased from</b> <u>9/25, 1961</u> <b>to</b> <u>10/12, 1961</u> <b>that (I) (we) last saw the deceased alive on</b> <u>10/12, 1961</u> <b>and that death occurred at</b> <u>1 P.M.</u> <b>from the causes and on the date stated above.</b>			
<b>22a. SIGNATURE</b> <u>William D. Gray M.D.</u>				<b>22b. DATE SIGNED</b> <u>10/13/61</u>		<b>22c. PHYSICIAN'S NAME (Type)</b> <u>Dr. William D. Gray M.D.</u>	
<b>22d. ADDRESS</b> <u>Camden Ave. Salisbury, Maryland</u>				<b>22e. REC'D BY REGISTRAR</b> <u>  </u>			
<b>22f. REGISTRAR'S SIGNATURE</b> <u>Arthur S. Thomas</u>				<b>22g. DATE</b> <u>  </u>			
<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>Burial</u>		<b>23b. DATE THEREOF</b> <u>Oct. 14, 1961</u>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Pittsville Cemetery</u>		<b>23d. LOCATION (City, town or county)</b> <u>Pittsville, Maryland</u>	
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <u>HOLLOWAY &amp; COMPANY</u>				<b>24b. ADDRESS</b> <u>SALISBURY MARYLAND</u>			
<b>24c. DATE</b> <u>OCT 17 '61</u>				<b>24d. SIGNATURE</b> <u>  </u>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law also requires that the death certificate be signed by the attending physician and completely filled in by the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

22051

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. If the death may be retained by the hospital or attending physician, the law requires that the death certificate be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
12046 Item 9 Film G299 11/2/61 12032											
1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>SALISBURY</u> c. LENGTH OF STAY IN 1b <u>4 days</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>PEN. GEN. HOSPITAL</u>						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Worcester</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>SHOWELLS</u> d. STREET ADDRESS <u>23X2</u> e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <u>VAUGHAN RUE TRUITT</u>						4. DATE OF DEATH <u>10 29 1961</u>					
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>OCT. 30, 1885</u>		9. AGE (In years last birthday) <u>75</u>		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>TEACHER, LAWYER</u>						10b. KIND OF BUSINESS OR INDUSTRY <u>SELF-EMPLOYED</u>		11. BIRTHPLACE (County & State, or foreign country) <u>SHOWELLS MD</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>FRANCIS C. TRUITT</u>						14. MOTHER'S MAIDEN NAME <u>JULIA OLIVE RUE</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>						16. SOCIAL SECURITY NO. <u>215-14-5603</u>		17. INFORMANT <u>MRS. V. R. TRUITT, SHOWELLS MD</u> Address			
18. CAUSE OF DEATH (Enter only one cause, or line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> 331X DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>331X</u> (c) DUE TO (e), stating the underlying cause first. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <u>Arteriosclerotic Heart Disease</u>										INTERVAL BETWEEN ONSET AND DEATH <u>72 hr.</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour e.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		20g. (County)		20h. (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>OCT. 26, 1961</u> to <u>OCT. 29, 1961</u> , that (I) (we) last saw the deceased alive on <u>OCT. 29, 1961</u> , and that death occurred at <u>4:28 P.M.</u> from the causes and on the date stated above.											
22a. SIGNATURE <u>David J. Gilman</u>						22b. DATE SIGNED		22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>CREMATION</u>						23b. DATE THEREOF <u>11/1/61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>LEE CREMATORY</u>		23d. LOCATION (City, town or county) (State) <u>WASHINGTON D.C.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Anna A. Burbage</u>						24a. ADDRESS <u>Bethesda Md</u>		25a. REC'D BY REGISTRAR <u>NOV 1 '61</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Frank</u>	

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22025

W. C. NICO

SALES

Gen. Com. Distribution

VACATION

M. W.

OCT 30 1933

TERENCE LAWRENCE SELF-EMPLOYED SHENANDOAH MOUNTAIN

FRANCIS C. TRUITT JULIA CLINE TRUITT

K. N. 212-14-2603 Mrs. V. R. Truitt, Shenandoah

George A. Binkley  
Washington D.C.  
11/1/33



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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12047  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

12033

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Delaware</u> b. COUNTY <u>Sussex</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Dagsboro</u>	
c. LENGTH OF STAY IN 1b		d. STREET ADDRESS <u>R.F.D. 46X-3</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Peninsula General Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Theresa Agnes Vickers</u>		4. DATE OF DEATH Month Day Year <u>October 23 1961</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5/30/1903</u>
9. AGE (In years last birthday) <u>58</u> yrs.		IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Housewife</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Del.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>CHARLES BRASURE</u>		14. MOTHER'S MAIDEN NAME <u>LAURA CAREY</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <u>NONE</u>	
17. INFORMANT Address <u>HARLEY VICKERS - DAGSBORO</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia</u> DUE TO (b) <u>Pulmonary atelectasis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>(Postoperative) Adeno-ca Cervix uteri</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u> <u>3 days</u>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>10/16, 1961</u> to <u>10/23, 1961</u> , that (I) (we) last saw the deceased alive on <u>10/23, 1961</u> , and that death occurred at <u>8:00 AM</u> , from the causes and on the date stated above.			
22a. SIGNATURE <u>Orlene Christensen</u> M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
22c. PHYSICIAN'S NAME (Type)		22b. DATE SIGNED	
22d. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>10/26/61</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>REDBIENS CEMETERY</u>		23d. LOCATION (City, town or county) (State) <u>DAGSBORO - DEL.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Ronald James - Millstone - Del.</u>		25a. REC'D BY REGISTRAR <u>26 '61</u>	
ADDRESS		25b. REGISTRAR'S SIGNATURE <u>Orlene Christensen</u>	

VR A15 (4)  
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19047

St. Louis 6

Enlistment

Enlistment General Hospital

K.D.

Thomas, Mrs. Vickers

Enlistment 23-01

Female White

2/30/1903

NY

Residence: Housewife

Del.

U.S.

CHARLES BRASURE & LAURA CANEY

None - WIKER VICKERS - DABRINO

2

Enlistment

Enlistment

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

12048

12034

<b>1. PLACE OF DEATH</b> e. COUNTY <b>Wicomico</b> <b>MARYLAND</b>		<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) e. STATE <b>Maryland</b> b. COUNTY <b>Somerset</b>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Crisfield</b>	
c. LENGTH OF STAY IN 1b <b>2 Mos. 5 Days</b>		d. STREET ADDRESS <b>Hoptown Road</b>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Deer's Head State Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>3. NAME OF DECEASED</b> (Type or print) First <b>Geneva</b> Middle <b>-----</b> Last <b>Ward</b>		<b>4. DATE OF DEATH</b> Month <b>October</b> Day <b>21</b> Year <b>19 61</b>	
<b>5. SEX</b> <b>Female</b>	<b>6. COLOR OR RACE</b> <b>Negro</b>	<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <b>June 26, 1899</b>
<b>9. AGE</b> (In years last birthday) <b>62 yrs.</b>		<b>10. BIRTHPLACE</b> (County & State, or foreign country) <b>Somerset, Maryland</b>	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>None</b>		<b>11. CITIZEN OF WHAT COUNTRY?</b> <b>U. S. A.</b>	
<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>None</b>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>U. S. A.</b>	
<b>13. FATHER'S NAME</b> <b>Jayson Norfleet</b>		<b>14. MOTHER'S MAIDEN NAME</b> <b>Delia Joyner</b>	
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <b>None</b>		<b>16. SOCIAL SECURITY NO.</b> <b>217-055043</b>	
<b>17. INFORMANT</b> <b>Hospital Records -- Salisbury, Maryland</b>		<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Thrombosis</b> DUE TO (b) <b>Generalized Arteriosclerosis</b> DUE TO (c) <b>5 yrs.</b>	
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		<b>20. INTERVAL BETWEEN ONSET AND DEATH</b> <b>2 mon</b>	
<b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)</b>			
<b>20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (If either, notify medical examiner) <input type="checkbox"/>		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)	
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour <b>a.m.</b> <b>19</b> p.m.		<b>20d. INJURY OCCURRED</b> While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town)</b> (County) (State)	
<b>21. I certify that (I) (this hospital) attended the deceased from 8/17/61, 19, to 10/21/61, 19, that (I) (we) last saw the deceased alive on 10/21/61, 19, and that death occurred at 12:00 P.M. from the causes and on the date stated above.</b>			
<b>22a. SIGNATURE</b> <b>Lee L. Lawry</b>		<b>22b. DATE SIGNED</b> <b>October 21, 1961</b>	
<b>22c. PHYSICIAN'S NAME (Type)</b> <b>Lee L. Lawry, M.D.</b>		<b>22d. ADDRESS</b> <b>Salisbury, Maryland</b>	
<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <b>Burial</b>		<b>23b. DATE THEREOF</b> <b>OCT 25 1961</b>	
<b>23c. NAME OF CEMETERY OR CREMATORY</b> <b>Asbury Cemetary</b>		<b>23d. LOCATION (City, town or county)</b> (State) <b>Crisfield MD.</b>	
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <b>Anthony E. Ward</b>		<b>25a. REC'D BY REGISTRAR</b> <b>OCT 25 '61</b>	
<b>25b. REGISTRAR'S SIGNATURE</b> <b>Arthur L. Thomas</b>			

PROSE

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

12049

CERTIFICATE OF DEATH

12035

1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>SALISBURY</b> c. LENGTH OF STAY IN 1b <b>Doz</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>PENINSULA GENERAL HOSPITAL</b>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>md</b> b. COUNTY <b>Wicomico</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>X Quantico md</b> d. STREET ADDRESS <b>10</b> e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>Vera Lee WEEMS</b>		4. DATE OF DEATH Month Day Year <b>OCTOBER 22 1961</b>					
5. SEX <b>FEMALE</b>		6. COLOR OR RACE <b>COLORED</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>9-15-1912</b>	
9. AGE (In years last birthday) <b>49 yrs.</b>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Domestic</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Pa</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Andrew J. Weems</b>				14. MOTHER'S MAIDEN NAME <b>Mona Watley</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>none</b>		16. SOCIAL SECURITY NO. <b>197-12-0589</b>		17. INFORMANT <b>Wilbur Weems</b> Address			
18. CAUSE OF DEATH (Enter only one cause per line for (e), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (e) <b>331X Cerebral Vascular Accident</b> Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. (b) <b>Hypertension</b> (c)				INTERVAL BETWEEN ONSET AND DEATH <b>25 days</b> <b>Indefinite</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>28 Sept 1961</b> to <b>22 Oct 1961</b> , that (I) (we) last saw the deceased alive on <b>22 Oct 1961</b> , and that death occurred at <b>6:35 AM</b> , from the causes and on the date stated above.							
22a. SIGNATURE <b>E.A. Purnell</b> M.D.				22b. DATE SIGNED <b>25 Oct 61</b>			
22c. PHYSICIAN'S NAME (Type) <b>E.A. Purnell</b>				22d. ADDRESS <b>6526 MAIN SALISBURY, MD.</b>			
23a. BURIAL CEMETERY, 23b. DATE THEREOF <b>Rem Burial 10-30-61</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Calvary Green mtn</b>		23d. LOCATION (City, town or county) (State) <b>West Chester Pa</b>			
24. FUNERAL DIRECTOR'S SIGNATURE <b>Booker McQuest</b> ADDRESS <b>Salisbury Md.</b>				25a. REC'D BY REGISTRAR DATE <b>OCT 27 '61</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Harris</b>	

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FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 7/59

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
12050 MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
12036											
1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> <u>MARYLAND</u>						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) e. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u>					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>						c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Peninsula General Hospital</u>						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <u>William Graham Weiland, Sr.</u>						4. DATE OF DEATH <u>10-16-61</u>					
5. SEX <u>M</u> 6. COLOR OR RACE <u>W</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH <u>Feb. 4, 1901</u>						9. AGE (In years last birthday) <u>60</u> 10. IF UNDER 1 YEAR Months <u>10</u> Days <u>16</u> 11. IF UNDER 24 HRS. Hours <u>19</u> Min.					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Lineman</u>						10b. KIND OF BUSINESS OR INDUSTRY <u>Electric Power</u>					
11. BIRTHPLACE (State or foreign country) <u>New York</u>						12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>					
13. FATHER'S NAME <u>Charles Weiland</u>						14. MOTHER'S MAIDEN NAME <u>Caroline Graham</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>						16. SOCIAL SECURITY NO. <u>109-05-77-40</u>					
17. INFORMANT <u>Mrs. Mary Weiland</u>						18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic heart disease</u> DUE TO (c) <u>Sudden</u> Years <u>Years</u>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>						20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>					
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)						20f. (City or town) (County) (State)					
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE <u>Earl L. Royer</u> M.D.						CHIEF MEDICAL EXAMINER <input type="checkbox"/>					
EXAMINER'S NAME (Type) <u>Earl L. Royer, M.D.</u>						ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>						22b. DATE THEREOF <u>10/20/1961</u>					
22c. NAME OF CEMETERY OR CREMATORY <u>Honeoye Falls Cemetery</u>						22d. LOCATION (City, town, or country) (State) <u>Honeoye Falls, New York</u>					
23. FUNERAL DIRECTOR <u>Thomas Haller</u> ADDRESS <u>Acacia City Rd. Salisbury, Maryland</u>						24a. REC'D BY REGISTRAR <u>10-18-61</u>					
24b. REGISTRAR'S SIGNATURE <u>Charles S. Hanna</u>						DATE SIGNED <u>10-16-61</u>					

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# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

12051

12037

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Wicomico</u> <b>MARYLAND</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u> c. LENGTH OF STAY IN b <u>Peninsula General</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)				<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u> d. STREET ADDRESS <u>R.D.# 5</u> e. 15 RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>3. NAME OF DECEASED</b> (Type or print) <b>WILFORD JAMES</b>		Last <u>White</u> <b>4. DATE OF DEATH</b> Month <u>October</u> Day <u>11</u> Year <u>1961</u>		<b>5. SEX</b> <u>Male</u> <b>6. COLOR OR RACE</b> <u>White</u> <b>7. MARRIED</b> <input checked="" type="checkbox"/> <b>NEVER MARRIED</b> <input type="checkbox"/> <b>WIDOWED</b> <input type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>			
<b>8. DATE OF BIRTH</b> <u>Sept. 24, 1906</u> <b>9. AGE</b> (In years last birthday) <u>55</u> yrs. IF UNDER 1 YEAR: Months <u>  </u> Days <u>  </u> IF UNDER 24 HRS.: Hours <u>  </u> Min. <u>  </u>		<b>10. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Farmer</u> <b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>Farming</u> <b>11. BIRTHPLACE</b> (County & State, or foreign country) <u>Silcoam, Maryland</u> <b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U S A</u>					
<b>13. FATHER'S NAME</b> <u>Purnell Davis White</u> <b>14. MOTHER'S MAIDEN NAME</b> <u>Sallie Bounds</u>		<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <u>No</u> (If yes give war or dates of service) <b>16. SOCIAL SECURITY NO.</b> <u>Mrs. Beatrice L. White (Wife) R.D.# 5</u> <u>Salisbury, Maryland</u>					
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.0</u> DUE TO <u>Arterio-sclerotic heart Disease unknown</u> Conditions, if any, which gave rise to immediate cause (b) <u>  </u> (e), stating the underlying cause last. (c) <u>  </u> DUE TO <u>  </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u>							
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH</b> (IF EITHER, NOTIFY MEDICAL EXAMINER) <b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.) <u>N/A</u>							
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. <u>N/A</u> p.m. <u>19</u>		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <u>N/A</u>			
<b>20f. (City or town)</b> <u>N/A</u>		<b>20g. (County)</b> <u>N/A</u>		<b>20h. (State)</b> <u>N/A</u>			
<b>21. I certify that (I) (this hospital) attended the deceased from</b> <u>10-1-1961</u> <b>to</b> <u>10-11-1961</u> , <b>that (I) (we) last saw the deceased alive on</b> <u>10-11-1961</u> , <b>and that death occurred at</b> <u>6 P.M.</u> <b>from the causes and on the date stated above.</b>							
<b>22a. SIGNATURE</b> <u>Wilbur R. Ellis Jr</u> <b>22c. PHYSICIAN'S NAME</b> (Type) <u>Dr. Wilbur R. Ellis Jr</u>				<b>ATTENDING PHYS.</b> <input checked="" type="checkbox"/> <b>MED. DIRECTOR</b> <input type="checkbox"/> <b>STAFF PHYS.</b> <input type="checkbox"/> <b>22d. ADDRESS</b> <u>Medical Center Salisbury, Maryland</u> <b>22b. DATE SIGNED</b> <u>10-11-61</u>			
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>Burial Oct. 13, 1961</u>		<b>23b. DATE THEREOF</b> <u>Oct. 13, 1961</u>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Spring Hill Mem. Gardens</u>			
<b>23d. LOCATION</b> (City, town or county) <u>R.D.# Salisbury, Maryland</u>		<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <u>HOLLOWAY &amp; COMPANY</u>					
<b>25a. REC'D BY REGISTRAR</b> <u>OCT 13 '61</u>		<b>25b. REGISTRAR'S SIGNATURE</b> <u>Arthur S. Kraus</u>					

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

12057

(M)

(A)

Sept. 24, 1906

X

White

White

White, Maryland

White

White

White

White

White

X

1/2

1/2

1/2

10-1

10-1

White

White

White

White

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

12052

12058

1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Wicomico</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Spring Hill Private Sanitarium</b>				d. STREET ADDRESS <b>Greenmount Ave.</b>			
3. NAME OF DECEASED (Type or print) First <b>MADELYN</b> Middle <b>P.</b> Last <b>WILSON</b>				4. DATE OF DEATH Month <b>OCTOBER</b> Day <b>29th</b> Year <b>61</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>March 3, 1904</b>	
9. AGE (In years last birthday) <b>57</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House Work at Home</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>		11. BIRTHPLACE (State or foreign country) <b>Sussex County Delaware</b>		12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>	
13. FATHER'S NAME <b>Medford Phillips</b>				14. MOTHER'S MAIDEN NAME <b>Janie Truitt</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO.		17. INFORMANT <b>Mr Eugene R. Wilson (Husband) #78 Greenmount Ave. Salisbury, Maryland</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Multiple sclerosis</b> <b>345X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>N/A</b>					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>N/A</b> <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>N/A</b>		20f. (City or town) (County) (State) <b>N/A</b>	
21. I certify that (I) (this hospital) attended the deceased from <b>9-8-59</b> to <b>10-29</b> 19 <b>61</b> , that (I) (we) last saw the deceased alive on <b>10-27</b> 19 <b>61</b> , and that death occurred at <b>5:45 A.M.</b> from the causes and on the date stated above.							
22a. SIGNATURE <b>H. A. Brielle</b>				22b. DATE <b>Oct. 30/1961</b>			
22c. PHYSICIAN'S NAME (Type) <b>Dr. Henry A/Brielle</b>				22d. ADDRESS <b>Medical Center Salisbury, Maryland</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Oct. 31, 1961</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Parsons Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Salisbury, Maryland</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>HOLLOWAY &amp; COMPANY</b>				25a. REC'D BY REGISTRAR <b>Oct 31 '61</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. House</b>	

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